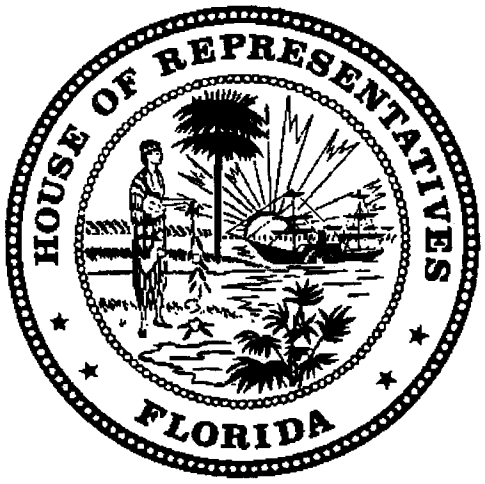

Health Care Appropriations Committee

Monday, April 17, 2006
3:00 p.m. – 4:00 p.m.
Morris Hall (17 HOB)

Meeting Packet

Allan Bense
Speaker

Aaron Bean
Chair

Florida House of Representatives

Fiscal Council
Health Care Appropriations Committee

Allan Bense
Speaker

Aaron Bean
Chair

Agenda
Monday, April 17, 2006
Morris Hall (17 HOB)
3:00 p.m. – 4:00 p.m.

I. Call to Order

II. Roll Call

III. Opening Remarks

IV. Consideration of the following bill(s):
- HB 393 Lead Poisoning Prevention Screening and Education Act by Joyner
- HB 1265 CS Small Business Health Care Insurance Assistance by Hukill
- HB 1319 CS Certification of Swimming Instructors by Goldstein
- HB 1327 CS Transition Services for Adolescents and Young Adults with Disabilities by Davis, D.
- HB 1365 CS Florida KidCare Program by Davis, M.
- HB 1409 Florida Health Information Network, Inc. by Benson
- HB 7139 Emergency Management by Health Care General Committee
- HB 7203 CS Prevention of Obesity by Health Care Regulation Committee

V. Closing Remarks

VI. Adjournment

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Health Care Appropriations Committee

Start Date and Time:	Monday, April 17, 2006 03:00 pm
End Date and Time:	Monday, April 17, 2006 04:00 pm
Location:	Morris Hall (17 HOB)
Duration:	1.00 hrs

Consideration of the following bill(s):

HB 393 Lead Poisoning Prevention Screening and Education Act by Joyner
HB 1265 CS Small Business Health Care Insurance Assistance by Hukill
HB 1319 CS Certification of Swimming Instructors by Goldstein
HB 1327 CS Transition Services for Adolescents and Young Adults with Disabilities by Davis, D.
HB 1365 CS Florida KidCare Program by Davis, M.
HB 1409 Florida Health Information Network, Inc. by Benson
HB 7139 Emergency Management by Health Care General Committee
HB 7203 CS Prevention of Obesity by Health Care Regulation Committee

NOTICE FINALIZED on 04/13/2006 16:22 by RYA

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 393 Lead Poisoning Prevention Screening and Education Act
SPONSOR(S): Joyner
TIED BILLS: **IDEN./SIM. BILLS:** SB 642

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee	8 Y, 0 N	Ciccone	Brown-Barrios
2) Health Care Appropriations Committee		Money WM	Massengale SM
3) Governmental Operations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

House Bill 393 creates the "Lead Poisoning Prevention Screening and Education Act."

The bill establishes a public information initiative for the purpose of communicating to the public the significance of lead poisoning prevention. The bill expands the Department of Health's role as the entity responsible for this initiative.

The bill establishes a screening program within the Department of Health to systematically screen children less than six years of age within certain categories and requires the Department of Health to maintain comprehensive screening records. The bill also requires the Department of Health to disclose cases or probable cases of lead poisoning to the affected individual, his or her parent or legal guardian if the individual is a minor, and to the secretary of the Department of Health.

The fiscal impact of this bill is estimated by the Department of Health at $798,802. The bill appropriates $308,000 in General Revenue. The provisions of this act will take effect upon the Department of Health receiving a federal lead poisoning prevention grant of $1 million or greater.

The bill provides an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provides limited government—This bill expands the Department of Health's health education and awareness activities with input from private industry.

Empower families—As a result of receiving certain public health advisements, this bill empowers families to choose housing or living accommodations based on accurate health-risk information.

B. EFFECT OF PROPOSED CHANGES:

Background

Because of potentially harmful effects, lead-based paints were banned from use in housing in 1978. Children are at particular risk for lead exposure because of their regular hand-to-mouth activity during daily play where lead-based paint is peeling or flaking. The dust from this deteriorating paint is easily ingested and is a significant source of exposure.

According to the Department of Health, lead poisoning became a reportable disease in 1992. Since then, more than 7,100 children in Florida have been identified with a confirmed case of lead poisoning. Lead poisoning can affect nearly every system in the body, and because lead poisoning often occurs with no obvious symptoms, it frequently goes unrecognized. Lead poisoning can cause learning disabilities, behavioral problems, and at very high levels, seizures, coma, and even death.

Program Background

The Childhood Lead Poisoning Prevention Program (CLPPP) was established in 1992 with a grant from the Centers for Disease Control and Prevention (CDC). The CLPPP currently operates within the Department of Health (DOH), Bureau of Community Environmental Health.

Since 1992, the state CLPPP has received up to $1 million annually from the CDC and distributes the majority of these funds to the Miami-Date, Pinellas, and Duval county health departments who continue to operate comprehensive childhood lead programs. However, because of anticipated federal grant reductions, the state may not receive the amount of money received in the past. A small amount of funding is also distributed to Broward, Hillsborough, Orange, Palm Beach and Polk counties. Like Miami-Date, Pinellas and Duval, these five counties also have a number of older housing units and a large population of at-risk children. In total, CDC funding supports 14 full-time and 7 part-time DOH staff.

The United States Department of Health and Human Services' Health People 2010 strategy for improving the Nation's health includes eliminating elevated blood lead levels in young children ages one to five years old. The CDC required all state and local CLPPP's to develop a strategic plan to meet this objective. To develop this plan, the CDC encouraged states to convene an advisory committee to assist in the development and implementation of the jurisdictional wide plan to eliminate lead poisoning. The Florida CLPPP convened an Advisory Committee in late 2003. The program worked with the committee to develop a statewide strategic plan to meet the elimination goal. The plan is available on the CDC website.[1]

[1] www.cdc.gov

Screening Background

Florida developed a statewide Screening Guideline (updated in 2001) with grant monies from the CDC, DOH, CLPPP and its advisory council, supporting the screening of children in at-risk groups. The document includes the Florida Agency for Health Care Administration requirement that all Medicaid eligible children receive a blood-lead test at age 12 months, age 24 months or between the ages of 36 and 72 months. The Screening Guideline provides a case management structure of services and interventions, which were updated in 2003 to meet the most current CDC recommendations. County CLPPPs collaborate with local partners to identify and ensure that children in high-risk groups are screened. They also assist private providers and the DOH's Children's Medical Service Program to provide care and treatment of children with elevated blood levels.

Effect of Bill

House Bill 393 creates the "Lead Poisoning Prevention Screening and Education Act." The bill asserts the Department of Health's role as the entity responsible for public health education, and expands DOH's health education responsibilities by establishing a program designed to increase public awareness on the hazards of lead-based paint poisoning. The bill also creates a collaborative public information initiative along with the Governor, the Secretary of Health, and private industry representatives to provide public service announcements and to develop and distribute culturally and linguistically appropriate information.

The bill establishes a statewide screening program for early identification of lead poisoning. The program provides screening for children younger than 6 years of age. Other than children, persons at risk are given priority for screening. The bill establishes guidelines for medical follow-up of children identified with elevated lead blood levels. The bill also requires the Department of Health to disclose cases or probably cases of lead poisoning to the affected individual, his or her parent or legal guardian if the individual is a minor, and to the secretary of the Department of Health. The secretary is required to maintain comprehensive records of all screenings conducted.

C. SECTION DIRECTORY:

Section 1. Creates an unnamed section to provide a popular name.

Section 2. Provides legislative findings related to lead poisoning.

Section 3. Creates definitions.

Section 4. Establishes the Lead Poisoning Prevention Educational Program; establishes a public information initiative; establishes distribution of literature about childhood lead poisoning.

Section 5. Establishes a lead screening program.

Section 6. Provides an appropriation.

Section 7. Provides that Sections 4, 5, and 6 shall take effect only upon the department receiving lead-poisoning prevention funds.

Section 8. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The lead poisoning prevention program is funded through a grant from the Center for Disease Control (CDC). The department will apply for grant funds (as in prior years) to continue the program for the 2006/07 fiscal year. The department's estimated cost to implement the bill is $798,802 as outlined below.

2. Expenditures:

For the 2006/07 fiscal year, $308,000 in recurring general revenue funds is appropriated to the Department of Health for the purposes of this act. Such an appropriation is contingent upon the Department of Health receiving a federal lead poisoning prevention grant of $1 million or greater.

	1st Year	2nd Year (Annualized/Recurring)
Salaries		
3 Environmental Spec I @$45,222 (1 Epidemiologist, 1 Screening Program Coord, and 1 Eval Spec)	$ 177,722	$ 183,054
1 Data Manager@$36,000	47,160	48,575
1 Admin Support Spec @$21,830	28,597	29,455
1 Outreach Coord @$42,000	55,020	56,571
(FTE computed w/31% fringe)		
Expense		
4 FTE @ Professional w/limited travel @$13,733 and 2 FTE @ support staff @ $7,986 first year	$ 70,904	$ 51,950
Screening costs @$20/screening	300,000	309,000
Case management of 63 cases	30,240	32,000
Educational materials	50,000	52,000
Screening database development	25,000	15,000
Operating Capital Outlay		
4 FTE @ Std. Professional package @ $1,900 and 2 FTE support staff @ $2,100	11,800	
HR Services FTE 4 @$393	2,358	2,358
Total Estimated Expenditures	$ 798,802	$ 780,063

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private industry organizations, including those involved in real estate, insurance mortgage banking and pediatrics would be solicited by the Department of Health in developing and coordinating a statewide public information initiative regarding the "Lead Poisoning Prevention Screening and Prevention Act." Health care providers and child care facility owners or operators would be responsible to distribute information pamphlets regarding childhood lead poisoning, testing, prevention and treatment.

D. FISCAL COMMENTS:

None

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None

B. RULE-MAKING AUTHORITY:

The Department of Health is provided the rulemaking authority to implement this act. Specifically, the bill would require the Secretary of Health to codify the current Childhood Lead Poisoning Screening Guidelines and medical follow-up guidelines.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

None.

A bill to be entitled

An act relating to the Lead Poisoning Prevention Screening and Education Act; providing a short title; providing legislative findings; providing definitions; providing for the establishment of a statewide comprehensive educational program on lead poisoning prevention; providing for a public information initiative; providing for distribution of literature about childhood lead poisoning; requiring the establishment of a screening program for early identification of persons at risk of elevated levels of lead in the blood; providing for screening of children; providing for prioritization of screening; providing for the maintenance of records of screenings; providing for reporting of cases of lead poisoning; providing an appropriation; providing contingencies for appropriation; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Short title.--This act may be cited as the "Lead Poisoning Prevention Screening and Education Act."

Section 2. Legislative findings.--

(1) Nearly 300,000 American children may have levels of lead in their blood in excess of 10 micrograms per deciliter (ug/dL). Unless prevented or treated, elevated blood-lead levels in egregious cases may result in impairment of the ability to think, concentrate, and learn.

(2) A significant cause of lead poisoning in children is

the ingestion of lead particles from deteriorating lead-based paint in older, poorly maintained residences.

(3) Childhood lead poisoning can be prevented if parents, property-owners, health professionals, and those who work with young children are informed about the risks of childhood lead poisoning and how to prevent it.

(4) Knowledge of lead-based-paint hazards, their control, mitigation, abatement, and risk avoidance is not sufficiently widespread.

(5) Most children who live in older homes and who otherwise may be at risk for childhood lead poisoning are not tested for the presence of elevated lead levels in their blood.

(6) Testing for elevated lead levels in the blood can lead to the mitigation or prevention of the harmful effects of childhood lead poisoning and may also prevent similar injuries to other children living in the same household.

Section 3. Definitions.--As used in this act, the term:

(1) "Affected property" means a room or group of rooms within a property constructed before January 1, 1960, or within a property constructed between January 1, 1960, and January 1, 1978, where the owner has actual knowledge of the presence of lead-based paint, that form a single independent habitable dwelling unit for occupation by one or more individuals and that has living facilities with permanent provisions for living, sleeping, eating, cooking, and sanitation. Affected property does not include:

(a) An area not used for living, sleeping, eating, cooking, or sanitation, such as an unfinished basement;

(b) A unit within a hotel, motel, or similar seasonal or transient facility, unless such unit is occupied by one or more persons at risk for a period exceeding 30 days;

(c) An area that is secured and inaccessible to occupants; or

(d) A unit that is not offered for rent.

(2) "Dust-lead hazard" means surface dust in a residential dwelling or a facility occupied by a person at risk which contains a mass-per-area concentration of lead equal to or exceeding 40 ug/ft2 on floors or 250 ug/ft2 on interior windowsills based on wipe samples.

(3) "Elevated blood-lead level" means a quantity of lead in whole venous blood, expressed in micrograms per deci liter (ug/dL), which exceeds 10 ug/dL or such other level as specifically provided in this act.

(4) "Lead-based paint" means paint or other surface coatings that contain lead equal to or exceeding 1.0 milligram per square centimeter, 0.5 percent by weight, or 5,000 parts per million (ppm) by weight.

(5) "Lead-based-paint hazard" means paint-lead hazards and dust-lead hazards.

(6) "Owner" means a person, firm, corporation, nonprofit organization, partnership, government, guardian, conservator, receiver, trustee, executor, or other judicial officer, or other entity which, alone or with others, owns, holds, or controls the freehold or leasehold title or part of the title to property, with or without actually possessing it. The definition includes a vendee who possesses the title, but does not include a

mortgagee or an owner of a reversionary interest under a ground rent lease. The term includes any authorized agent of the owner, including a property manager or leasing agent.

(7) "Paint-lead hazard" means any one of the following:

(a) Any lead-based paint on a friction surface that is subject to abrasion and where the dust-lead levels on the nearest horizontal surface underneath the friction surface, such as the windowsill or floor, are equal to or greater than the dust-lead-hazard levels defined in subsection (2);

(b) Any damaged or otherwise deteriorated lead-based paint on an impact surface that is caused by impact from a related building material, such as a door knob that knocks into a wall or a door that knocks against its door frame;

(c) Any chewable lead-based painted surface on which there is evidence of teeth marks; or

(d) Any other deteriorated lead-based paint in or on the exterior of any residential building or any facility occupied by a person at risk.

(8) "Person at risk" means a child under the age of 6 years or a pregnant woman who resides or regularly spends at least 24 hours per week in an affected property.

(9) "Secretary" means the secretary of the Department of Health or a designee chosen by the secretary to administer the Lead Poisoning Prevention Screening and Education Act.

(10) "Tenant" means the individual named as the lessee in a lease, rental agreement, or occupancy agreement for a dwelling unit.

Section 4. Educational programs.--

(1) LEAD POISONING PREVENTION EDUCATIONAL PROGRAM ESTABLISHED.--In order to achieve the purposes of this act, a statewide, multifaceted, ongoing educational program designed to meet the needs of tenants, property owners, health care providers, early childhood educators, care providers, and realtors is established.

(2) PUBLIC INFORMATION INITIATIVE.--The Governor, in conjunction with the Secretary of Health and his or her designee, shall sponsor a series of public service announcements on radio, television, the Internet, and print media about the nature of lead-based-paint hazards, the importance of standards for lead poisoning prevention in properties, and the purposes and responsibilities set forth in this act. In developing and coordinating this public information initiative, the sponsors shall seek the participation and involvement of private industry organizations, including those involved in real estate, insurance, mortgage banking, and pediatrics.

(3) DISTRIBUTION OF LITERATURE ABOUT CHILDHOOD LEAD POISONING.--By January 1, 2007, the Secretary of Health or his or her designee shall develop culturally and linguistically appropriate information pamphlets regarding childhood lead poisoning, the importance of testing for elevated blood-lead levels, prevention of childhood lead poisoning, treatment of childhood lead poisoning, and, where appropriate, the requirements of this act. These information pamphlets shall be distributed to parents or the other legal guardians of children 6 years of age or younger on the following occasions:

(a) By a health care provider at the time of a child's

birth and at the time of any childhood immunization or vaccination unless it is established that such information pamphlet has been provided previously to the parent or legal guardian by the health care provider within the prior 12 months.

(b) By the owner or operator of any child care facility or preschool or kindergarten class on or before October 15 of the calendar year.

Section 5. Screening program.--

(1) The secretary shall establish a program for early identification of persons at risk of having elevated blood-lead levels. Such program shall systematically screen children under 6 years of age in the target populations identified in subsection (2) for the presence of elevated blood-lead levels. Children within the specified target populations shall be screened with a blood-lead test at age 12 months and age 24 months, or between the ages of 36 months and 72 months if they have not previously been screened. The secretary shall, after consultation with recognized professional medical groups and such other sources as the secretary deems appropriate, promulgate rules establishing:

(a) The means by which and the intervals at which such children under 6 years of age shall be screened for lead poisoning and elevated blood-lead levels.

(b) Guidelines for the medical followup on children found to have elevated blood-lead levels.

(2) In developing screening programs to identify persons at risk with elevated blood-lead levels, priority shall be given to persons within the following categories:

(a) All children enrolled in the Medicaid program at ages 12 months and 24 months, or between the ages of 36 months and 72 months if they have not previously been screened.

(b) Children under the age of 6 years exhibiting delayed cognitive development or other symptoms of childhood lead poisoning.

(c) Persons at risk residing in the same household, or recently residing in the same household, as another person at risk with a blood-lead level of 10 ug/dL or greater.

(d) Persons at risk residing, or who have recently resided, in buildings or geographical areas in which significant numbers of cases of lead poisoning or elevated blood-lead levels have recently been reported.

(e) Persons at risk residing, or who have recently resided, in an affected property contained in a building that during the preceding 3 years has been subject to enforcement for violations of lead-poisoning-prevention statutes, ordinances, rules, or regulations as specified by the secretary.

(f) Persons at risk residing, or who have recently resided, in a room or group of rooms contained in a building whose owner also owns a building containing affected properties which during the preceding 3 years has been subject to an enforcement action for a violation of lead-poisoning-prevention statutes, ordinances, rules, or regulations.

(g) Persons at risk residing in other buildings or geographical areas in which the secretary reasonably determines there to be a significant risk of affected individuals having a blood-lead level of 10 ug/dL or greater.

(3) The secretary shall maintain comprehensive records of all screenings conducted pursuant to this section. Such records shall be indexed geographically and by owner in order to determine the location of areas of relatively high incidence of lead poisoning and other elevated blood-lead levels.

All cases or probable cases of lead poisoning found in the course of screenings conducted pursuant to this section shall be reported to the affected individual, to his or her parent or legal guardian if he or she is a minor, and to the secretary.

Section 6. For the 2006-2007 fiscal year, $308,000 in recurring general revenue funds is appropriated to the Department of Health for the purpose of this act. For the 2006-2007 fiscal year, $1 million is appropriated to the Administrative Trust Fund in the Department of Health for the purpose of this act.

Section 7. Sections 4, 5, and 6 shall take effect only upon the Department of Health receiving federal lead-poisoning-prevention funds of $1 million or greater.

Section 8. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1265 CS Small Business Health Care Insurance Assistance
SPONSOR(S): Hukill and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2428

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	10 Y, 0 N, w/CS	Halperin	Mitchell
2) Insurance Committee	18 Y, 0 N	Tinney	Cooper
3) Health Care Appropriations Committee		Speir WS	Massengale
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

The bill creates a statewide two-year pilot program to be called "The Small Business Health Care Insurance Assistance Pilot Program." The program is designed to encourage small businesses to offer comprehensive major medical health insurance to their respective employees. Under the bill, the pilot program will offer companies with more than one, but fewer than six employees, a one-time rebate of $1,000 per employee covered to help pay the premiums. Employers are required to pay at least 50 percent but less than 100 percent of the cost of coverage, and employees are required to contribute the remaining cost.

The bill states the pilot program shall be funded by $15 million in general revenue funds and will be administered by the Agency for Health Care Administration (AHCA).

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote Personal Responsibility—The bill encourages small businesses and individual employees each to pay a portion of the cost of health insurance coverage and then proposes a $1,000 rebate to eligible employers per covered employee. The bill indicates funds for the rebate will be provided from the General Revenue Fund.

Empower Families—The bill increases the opportunity for small-business employees to receive the benefits of health insurance.

B. EFFECT OF PROPOSED CHANGES:

Background

House Bill 1265 CS is the product of recommendations by a diverse Citizen Advisory Committee that was commissioned by Representative Dorothy Hukill in December 2005. The advisory committee discussed various ideas for legislation to provide support and incentives to small businesses for offering health insurance coverage to their employees.[1]

Structure of the Pilot Program

House Bill 1265 CS creates the Small Business Health Care Insurance Assistance Pilot Program as a statewide pilot program for two years. The program is designed to encourage small businesses with more than one and fewer than six employees to provide full comprehensive major medical health insurance for employees for the first time. The program will offer a one-time rebate of $1,000 per employee covered while requiring both employers and employees to contribute to the cost of the policies.[2] Employers must pay at least 50 percent, but less than 100 percent, of the cost of coverage, and employees are required to pay the remaining cost. Employers seeking the rebate must demonstrate that they have provided such coverage to their employees for the first time.

The bill specifies that a business is eligible for the rebate if, at the time of applying, the business had provided and paid for such coverage for 12 consecutive months, but had not previously provided such coverage for at least 6 months prior to the 12-month period. Businesses may only receive the rebate once.

The pilot program is to be administered by the Agency for Health Care Administration (AHCA). Applicants must apply for the rebate through the agency. The bill requires AHCA to adopt rules necessary to administer and ensure accountability of the pilot program, and to enforce compliance with the requirements of the program.[3] The bill also authorizes AHCA to audit a business applying for rebates to ensure compliance with eligibility requirements.

The bill states that it is the intent of this act to allocate $15 million in general revenue funds to establish a statewide pilot program. The bill also requires the program to be funded by general revenue.

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[1] Information available at:: http://www.myhometownnews.net/index.php?id=3517; viewed April 2, 2006.
[2] The bill specifies employees are to be counted based on the employer's Florida Unemployment Compensation Tax Form 6.
[3] The bill directs AHCA to adopt rules pursuant to ss. 120.536(1) and 120.54, F.S.

PRESENT SITUATION

This bill addresses the ability of small businesses in Florida to provide health insurance coverage for employees. According to the Office of Labor Market Statistics of the Agency for Workforce Innovation, at the end of 2004, an estimated 62.3 percent (488,595) of the businesses in Florida employed between one and four workers. Businesses that are required to pay the most for health insurance are often the ones that can least afford it. Small businesses cannot dilute their risk by spreading it over large numbers of employees so insurance providers compensate by charging small businesses higher per-employee rates.[4] Proponents of the pilot program report the bill will both assist small businesses in providing insurance coverage, and will save the state money above the cost of the program by reducing the number of uninsured patients who rely on emergency room visits as their primary source for health care.[5]

Overview of the Uninsured

More than 45 million Americans are uninsured, with nearly 60 percent of those employed by small businesses.[6] Although the majority of Americans obtain insurance through their employer as a benefit, employment does not guarantee coverage. The uninsured are primarily working families with low and moderate incomes for whom coverage is not available in the workplace or is unaffordable. Medicare covers most citizens age 65 and older, while Medicaid and the State Children's Health Insurance Program (SCHIP) provide coverage for millions of low-income people. There remains a significant gap in coverage, in part because employer-sponsored health insurance is sensitive to changes in the general economy and in rising insurance premiums. Between the years 2000 and 2002, there was a nearly 10 percent growth in the number of uninsured Americans.[7]

Consequences of the Uninsured

There is a strong relationship between insurance coverage and access to medical services. Health insurance influences the amount and type of care that people are able to afford, and increases the ability of people to seek preventative care. Insurance coverage improves overall health and is estimated to reduce mortality rates by 10 to 15 percent. For example, according to Florida Cancer Registry data, the uninsured have a 70 percent greater chance of a late diagnosis, which significantly decreases the chances of a positive health outcome.[8] The uninsured are more likely to be hospitalized for avoidable health problems and are more likely to be diagnosed in the late-stages of disease. Insurance also has an impact on the financial well-being of families: insurance helps reduce financial uncertainty associated with health care, and reduces vulnerability to unexpected out-of-pocket costs.

The problem of the uninsured impacts not just those individuals and families without coverage, but also has considerable externalities on employers and on the state. The cost of uncompensated care in the United States totaled about $36 billion in 2001, about 75—80 percent of which was paid for by federal and state dollars directly to hospitals. According to AHCA, uncompensated care in Florida's hospitals totaled more than $4.3 billion in 2001 and is growing at the rate of 12—13 percent per year.[9]

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[4] Information available at: http://www.microsoft.com/smallbusiness/resources/finance/business_insurance/best_and_worst_states_for_health_insurance_costs.mspx; viewed April 2, 2006.
[5] *See supra*, Note 1.
[6] *See supra*, Note 4.
[7] Henry J. Kaiser Family Foundation; Kaiser Commission on Medicaid and the Uninsured; "The Uninsured and Their Access to Health Care;" November 2005; available at: http://www.kff.org/uninsured/upload/The-Uninsured-and-Their-Access-to-Health-Care-Fact-Sheet-6.pdf; viewed April 2, 2006.
[8] Florida Cancer Registry; available at: http://www.doh.state.fl.us/Disease_Ctrl/epi/cancer/CancerIndex.htm; viewed April 2, 2006.
[9] Florida Insurance Council; "Governor Bush announces creation of Governor's Task Force on Access to Affordable Health Insurance;" available at: http://www.flains.org/newfic/mediapublic/latebreakingnews/govhealth825.html; viewed April 2, 2006.

The Uninsured in Florida

Approximately 22.2 percent of the adults in Florida, and 12 percent of the children were without health insurance in 2004. Employees of small-businesses appear to have an especially difficult time obtaining or affording health insurance. The 2004 Florida Health Insurance Study[10] (FHIS 2004) evaluated levels of insurance coverage based on both employment status of the individual, and on the size of the firm. The study found that approximately 48.1 percent of the unemployed in Florida are also uninsured. The study further reported that obstacles to employer-provided health insurance are greatest for the smallest firms. In companies with four or fewer employees, 36.3 percent of workers are uninsured; in companies with between five and nine employees, 35.2 percent of workers are uninsured; in companies with between 10 and 24 employees, 31.8 percent are uninsured; and in companies with between 25 and 49 employees, 22.7 percent are uninsured. Rates of coverage increase significantly for larger firms.

Among uninsured employed adults, the reasons for lacking coverage vary. A strong majority of 69 percent report that the employer does not offer insurance. For 13.6 percent, the employer offers insurance but the employee is ineligible for coverage; for 12.7 percent, the employer offers insurance but the cost sharing for the employee is too high; and 4.5 percent of uninsured employees declined for other reasons. Finally, 32 percent of exclusively self-employed workers are uninsured.

Costs of Insurance

Since 2000, the cost of health insurance in the United States has increased by 73 percent. In 2005, premiums for family coverage increased 9.2 percent nationally with comparable rates in Florida. This is the first year of single digit increases since 2000. The 9.2 percent increase exceeds the overall rate of inflation by nearly 6 percentage points and the increase in workers' earnings by over 6 percentage points. Covered workers in small firms experienced even greater premium increases of 9.8 percent.

The average cost of single coverage for covered workers in 2005 is $335 per month or $4,024 per year. This figure includes both the employer and employee contribution. The average cost of family coverage is $10,880 a year, which exceeds the annual gross earnings of a minimum wage worker who is fully employed throughout the year. Premiums further vary based on the type of policy workers are covered under. Preferred Provider Organizations plans have the highest enrollment and face higher average premiums for both single and family coverage than Health Maintenance Organizations plans. The average premium for workers in PPO plans is $4,150 for the individual and $11,090 for the family, while the average premium for workers in HMO plans is $3,767 for the individual and $10,556 for the family.[11]

The Medical Expenditure Panel Survey (MEPS) is conducted annually by the federal Agency for Healthcare Research and Quality and evaluates the price of insurance coverage across the states. According to the 2000 Employer-Sponsored Health Insurance Data, Florida was rated the seventh most expensive state in the average insurance premiums that small businesses pay for family coverage.[12]

Other Efforts to Help Small Businesses Provide Health Insurance

There are currently a number of national and state efforts to increase the capacity of small businesses to provide health coverage for employees. The U.S. Chamber of Commerce and the Florida Chamber of Commerce, in particular, support the Health Savings Accounts (HSAs) and group association rates. The U. S. Chamber of Commerce encourages expansion of the HSAs to make it easier for small

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[10] Agency for Health Care Administration; 2004 Florida Health Insurance Study; available at: http://ahca.myflorida.com/Medicaid/quality_management/mrp/Projects/fhis2004/; viewed April 2, 2006.
[11] Henry J. Kaiser Family Foundation; "Employer Health Benefits 2005 Annual Survey;" available at: www.kff.org/insurance/7315/sections/ehbs05-sec-1-print.cfm/; viewed April 2, 2006.
[12] U.S. Department of Health & Human Services; Agency for Healthcare Research and Quality; The Medical Expenditure Panel Survey (MEPS); available at: http://www.meps.ahrq.gov/; viewed April 2, 2006.

businesses and individuals to receive coverage and lobbies for the passage of legislation establishing Association Health Plans, which allow small businesses to pool risk and access health coverage.[13] Incentive plans in other states include pilot programs to allow small businesses to buy into the state employee's health care system at no cost to the state;[14] proposals to offer incentives for insurance companies to cut the cost of premiums in exchange for reductions in the premium tax they pay to the state; $1,000 tax credit rewards to small businesses that offer health care; and proposals to reduce the number of coverage items mandated by state government in order to reduce the cost of coverage.[15]

C. SECTION DIRECTORY:

Section 1. Creates law, provides legislative intent, and authorizes a two-year pilot program called The Small Business Health Care Insurance Pilot Program.

Section 2. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   To the extent state funds are available to offset health insurance premiums paid by small businesses on behalf of their employees, local monies for health care may be supplanted by state monies.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Eligible small businesses, that is, those with 1 to 6 employees, may apply for state subsidies of $1,000 each to help pay annual health insurance premiums for their respective employees. The bill specifies the eligibility requirements and application process for the state subsidy.

D. FISCAL COMMENTS:

The language of the bill is ambiguous as to whether a $15 million appropriation is made in the bill. The bill states, "It is the intent of this act to establish a statewide pilot program that will allocate $15 million for general revenue for such purposes."

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[13] U.S. Chamber of Commerce; Health Care: Policy Priorities for 2005-2006; available at: http://www.uschamber.com/issues/priorities/healthcare.htm; viewed April 2, 2006.
[14] Kansas Small Business; Kenneth Daniel; "Health Insurance Solutions for Kansas Small Businesses; available at: http://www.kssmallbiz.com/articles/article_442.asp; viewed April 2, 2006.
[15] Health Care's Foundation Crumbling; Amanda J. Crawford; *The Arizona Republic*; January 15, 2005; available at: http://www.azcentral.com/specials/special46/articles/0115HCR-overview15.html; viewed April 2, 2006.

The bill also states, "The pilot program shall be funded by general revenue." These two sections may be interpreted as appropriating general revenue funds for the Small Business Health Care Insurance Assistance Pilot Program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill grants rulemaking authority to AHCA to administer the Small Business Health Care Insurance Assistance Program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to small business health care insurance assistance; providing legislative intent; establishing a pilot program to provide rebates to small businesses providing comprehensive major medical health insurance coverage for employees; requiring employer and employee participation in certain costs; specifying the amount of the rebate; providing for additional eligibility for certain businesses; providing for payment of the rebates from general revenue; providing for administration of the program by the Agency for Health Care Administration; requiring the agency to adopt rules; providing enforcement and audit authority for the agency; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. (1) It is the intent of the Legislature to encourage small businesses to provide comprehensive major

medical health insurance coverage to employees of the businesses. It is the intent of this act to establish a statewide pilot program that will allocate $15 million from general revenue for such purposes.

(2) The Small Business Health Care Insurance Assistance Pilot Program is created as a statewide pilot program for a period of 2 years to provide a one-time rebate for small businesses that employ more than one but fewer than six employees and that provide full coverage of comprehensive major medical health insurance for such employees pursuant to s. 627.6699, Florida Statutes. The employer shall pay at least 50 percent but less than 100 percent of the cost of the coverage, and the employees must share in the remainder of the cost of the coverage.

(3)(a) The amount of the rebate shall be $1,000 per each employee as reported on the business' Florida unemployment compensation tax form 6.

(b) A small business must apply through the Agency for Health Care Administration.

(c) A business is eligible for the rebate under this section if, at the time of applying for a rebate under the pilot program, the business had provided and paid for such coverage for 12 consecutive months but had not provided and paid for such coverage for at least 6 months prior to such 12-month period. The business may receive the rebate only one time.

(4) The pilot program shall be funded by general revenue and shall be administered by the Agency for Health Care Administration. The agency shall adopt any rules pursuant to ss.

120.536(1) and 120.54, Florida Statutes, necessary to administer and ensure accountability of the pilot program and enforce compliance with the requirements of the program. The agency may conduct audits of any business applying for rebates under the program to ensure compliance with program requirements.

Section 2. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1319 CS Certification of Swimming Instructors
SPONSOR(S): Goldstein
TIED BILLS: **IDEN./SIM. BILLS:** SB 2426

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N, w/CS	Halperin	Mitchell
2) Business Regulation Committee	17 Y, 0 N	Watson	Liepshutz
3) Health Care Appropriations Committee		Ekholm	Massengale
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

This bill requires additional certification of swimming instructors at swimming pools who hold themselves out as specializing in training people with developmental disabilities. It requires the certification to be obtained from the Dan Marino Foundation, based in Weston, Florida. The bill further requires the Dan Marino Foundation to develop certification requirements and training curriculum for review by the Department of Health.

The bill provides the Department of Health with the authority to enforce compliance.

The bill allocates $535,000 from the General Revenue Fund to the department for the purpose of implementing the act, to be distributed as follows:

- $185,000 in recurring revenue to the Dan Marino Foundation, Inc., to implement and operate the certification program.
- $350,000 in nonrecurring revenue to the Dan Marino Foundation, Inc., to develop curriculum for training and certification requirements, in addition to assisting with facilities to accommodate the developmentally disabled.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—The bill adds new certification requirements to the practice of swimming instruction in Florida.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Section 514.071, F.S. requires that any person working as a swimming instructor or lifeguard at a public swimming pool must be certified by the American Red Cross, the Y.M.C.A., or another nationally recognized aquatic training program.[1] Swimming instructors are to be certified in swimming instruction, first aid, and cardiopulmonary resuscitation. Rule 64E-9.008, F.A.C., further requires that swimming instructors be certified in child and infant cardiopulmonary resuscitation through the American Red Cross, or the American Heart Association or the National Safety Council. In terms of enforcement, the Department of Health may currently sue to enjoin the operation of any public swimming pool that uses any swimming instructor or lifeguard in violation of this section, in addition to any other remedies available to the department.

Current Swimming Instruction Provided to Developmentally Disabled Children

Broward County has a unique program for serving developmentally disabled individuals, and currently provides instruction to between 4,000 and 5,000 special needs children each year in their regular swim instruction program.

Developmental Disabilities in Florida

Section 393.063(10), F.S., defines a developmental disability as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely. Developmental disabilities begin anytime during development up to 22 years of age and usually last throughout a person's lifetime.[2] As of 2003, there were 7,151 children with autism in Florida. This represents a 690 percent cumulative growth rate of autism from 1992 to 2003, or an average annual growth rate of 19 percent. The increase in autism prevalence is systemic across the United States with rates having grown from 1 in 10,000 births in the 1980s to 1 in 166 births today.[3]

Proponents of the bill claim that many developmentally disabled children are not being taught to swim properly because instructors lack expertise in training special needs students. While teachers in

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[1] Pursuant to Rule 64E-9.008, "nationally recognized aquatic training programs" adopt as reference the standards found in the 2000 edition of the American Red Cross Lifeguarding Instructors Manual, the 1995 edition of the American Red Cross Water Safety Guide for Training Instructors, the On the Guard II, The YMCA Lifeguard Manual, Fourth Edition, (YMCA) The Youth and Adult Aquatic Program Manual (1999), and (YMCA) The Parent/Child and Preschool Aquatic Program Manual (1999).

[2] U.S. Centers for Disease Control. http://www.cdc.gov/ncbddd/dd/default.htm.

[3] Public Schools Autism Prevalence Report Series, 1992-2003, www.fightingautism.org. Data Note: The Individuals with Disabilities Education Act (IDEA) requires each state's Department of Education and the U.S. Department of Education to record specific childhood disabilities, including autism, for each school year. This means that in order for a child to be recorded in the autism disability category the student must require special academic support for the disability; and means that some children with autism who attend private school or other facilities are not included in these counts. Data sources include www.ideadata.org and www.cdc.gov.nchs/.

classrooms must receive additional certification to instruct special needs children, swimming instructors are not required to have additional training.

Florida Geography

Florida has 11,761 square miles covered by water, making it the third wettest state behind Alaska and Michigan.[4] Florida also has the second longest coastline of 1,350 miles, and the second longest shoreline of 8,426 miles.[5] Approximately 80 percent of residents live by the coast, and no resident is more than 75 miles from water.[6]

Drowning Statistics

Drowning is the second leading cause of injury death of infants and children younger than 15 years of age in the United States, and children under the age of five have the highest drowning rates. For every child who drowns, four children are hospitalized for near-drowning. Of the estimated 5,000 children who are hospitalized annually for near-drowning, 15 percent die in the hospital and one-third suffer significant neurological damage. In Florida, drowning is the leading cause of death to children age 14 and younger[7], and the state has the highest number of drowning accidents in the nation.[8] Children younger than one year of age are most likely to drown in bathtubs and buckets, while children between the ages of 1 and 4 most frequently drown in residential swimming pools. Children usually enter pools through unprotected gates and are only out of eyesight for moments before immersing in the water. Children and adolescents between the ages of 5 and 19 most often drown in lakes, ponds, rivers and pools. The annual cost of care per year for an impaired survivor of a near-drowning is approximately $100,000.[9]

Factors That Increase the Risk of Drowning

Some underlying medical conditions are known to increase the risk of drowning. Persons with developmental disabilities are at higher risk of pedestrian accidents in general, including falls, fires, and drowning.[10] Children with epilepsy are estimated to be 4 to 14 times more at risk of submersion;[11] and two recent studies suggest that children with autism may also be at increased risk.[12] However, both studies are based on a small number of drowning deaths and more research is necessary to evaluate the relation between autism and drowning. For some parents of children with autism, fears about the child's wellbeing sometimes lead them entirely to avoid swimming lessons.[13] Minority and underprivileged children are also at increased risk of drowning. According to 2002 statistics, 40 percent

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[4] http://www.netstate.com/states/geography/fl_geography.htm.
[5] http://www.50states.com/florida.htm.
[6] Florida Department of Environmetnal Protection. http://www.floridadep.org/law/grants/cmp/.
[7] Orange County, CA, Fire Authority. http://www.poolalarms.com/pool_drowning_statistics.htm.
[8] http://www.poolalarms.com/statistics_florida_swimming_pool_accidents.htm.
[9] Statistics on Drowning. http://hsc.usf.edu/CLASS/JulieJ/Statistics.htm.
[10] Strauss, D., Shavelle, R., Anderson, T. and Baumeister, A. "External Causes of Death among Persons with Developmental Disability." *American Jounral of Epidemiology.* 1998, Vol. 147, No. 9: 855-862. http://aje.oxfordjournals.org/cgi/content/abstract/147/9/855
[11] Smith GS, Brenner RA. The changing risks of drowning for adolescents in the US and effective control strategies. *Adolescent Medicine.* 1995; 6 :153 –170. See also footnotes 39-41 in Brenner, R.A. "Prevention of Drowning in Infants, Children, and Adolescents. *Pediatrics.* Vol. 112 No. 2 August 2003, pp. 440-445. Available at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/2/440.
[12] Sibert JR, Lyons RA, Smith BA, et al. Preventing deaths by drowning in children in the United Kingdom: have we made progress in 10 years? Population based incidence study. *British Journal of Medicine* .2002; 324 :1070–1071; and Shavelle RM, Strauss DJ, Pickett J. Causes of death in autism. *Journal of Autism and Developmental Disorders.* 2001; 31 :569 –576.
[13] Life Science Services Contract with NASA.http://fitness.ksc.nasa.gov/articles/autism.php.

of children who die from drowning are minority children. This is based on factors of race, class, privilege and poverty that limit a child's access to aquatic facilities and swimming lessons. [14]

Effect of Proposed Changes

This bill creates s. 514.072, F.S., requiring additional certification of individuals working at pools who hold themselves out as specializing in training people with developmental disabilities, as defined in s. 393.063(10), F.S.

The bill provides that the "special needs" swimming instructor certification requirements will be developed by the Dan Marino Foundation, Inc., and instructors must meet these additional certification requirements to teach individuals with developmental disabilities. The bill requires the Dan Marino Foundation, Inc., to submit the certification requirements to the Department of Health for review and incorporation into rule by January 1, 2007.

Swimming instructors at public pools are currently certified under s. 514.071, F.S., before July 1, 2007, must meet the additional requirements by January 1, 2008. Individuals certified under s. 514.071, F.S., on or after July 1, 2007, must meet the additional requirements within 6 months after receiving the original certification.

In addition to attaining the special certification outlined in this bill, instructors at private pools holding themselves out as specialists in training students with developmental disabilities would be required to get the same certification as regular swimming instructors at public schools.

In addition to other remedies available to the Department of Health, the bill provides the department the right to sue to prohibit or restrain by injunction the operation of any public swimming pool that uses any swimming instructor in violation of certification requirements.

The effective date of the bill is July 1, 2006.

New Certification Requirements

The certification program required in the bill is being drafted by a workgroup organized by the Broward County Swim Central in conjunction with the Dan Marino Foundation. The new proposed certification requirements are not currently available for review. According to the Department of Health analysis on this bill, there are currently nationally recognized courses that are required for swimming instructors and lifeguards. It is not known how the certification requirements in the bill will integrate with the national requirements for certification. The department suggests that an alternative way of designing additional certification requirements is to submit the idea to the Red Cross, YMCA or other national swimming instruction program for incorporation into existing swimming courses for certification.

About the Dan Marino Foundation

The Dan Marino Foundation, Inc., is based in Weston, Florida, and was founded in 1992 as a non-profit organization supporting medical, emotional or behavioral programs that provide integrated intervention services for children with special needs. The foundation has distributed and pledged over $7 million dollars to provide research, programs, and services that have benefited more than 100,000 children. [15]

[14] Anderson, Kelli. "Just Add Water: A Complete Guide to Aquatic Centers." *Recreation Management.* http://www.recmanagement.com/feature_print.php?fid=200602fe01.
[15] Dan Marino Foundation, Inc. www.danmarinofoundation.org.

C. SECTION DIRECTORY:

Section 1. Creates s. 514.072, F.S., requiring additional certification for swimming instructors who teach people who have developmental disabilities.

Section 2. Provides an appropriation of $535,000.

Section 3. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appropriates $535,000 from General Revenue to the Department of Health for the purpose of implementing the act, to be distributed as follows:
   - $185,000 in recurring revenue to the Dan Marino Foundation, Inc., to implement and operate the certification program.
   - $350,000 in nonrecurring revenue to the Dan Marino Foundation, Inc., to develop curriculum for training and certification requirements, in addition to assisting with facilities to accommodate the developmentally disabled.

According to Department of Health analysis, staff time spent at public pools will need to be increased during the routine inspections, which will result in additional costs. Increased violations could also result in a significant increase in the workload of department legal staff. The amount of these costs are both indeterminate at this time. The department is responsible for 34,000 public pools statewide.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

2. Revenues:

   None.

3. Expenditures:

   See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments.

D. FISCAL COMMENTS:

According to Department of Health analysis, each city or county that operates a public pool and offers swimming instruction to developmentally disabled persons will incur a cost for each staff member certified under the requirements of bill. Travel costs may be also be incurred for instructors to go to Broward County to receive training and certification.[16]

[16] Berrios, J. "Swimming teachers could get extra duties." *Miami Herald.* March 20, 2006. http://www.miami.com/mld/miamiherald/news/local/states/florida/counties/broward_county/13994776.htm.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Although the bill requires counties and municipalities to spend funds or take an action requiring the expenditure of funds, the impact is less than $1.8 million and is insignificant. The bill is therefore exempt from the provisions of Article VII, Section 18(b), Florida Constitution.

This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None required.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The department suggests that the certification proposed in the bill be done initially in Broward County to ensure its effectiveness prior to implementation statewide.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 28, 2006, the Health Care Regulation Committee adopted a strike-all amendment to the bill and reported the bill favorably with a committee substitute. The amendment provided the following changes:

- Allocates entire appropriation of $535,000 to the Dan Marino Foundation, Inc., for the 2006-2007 fiscal year for purpose of implementing this act; rather than having funding go toward different entities.

- Requires the Dan Marino Foundation to develop certification requirements and training curriculum for swimming instructors of people who have developmental disabilities; and requires them to submit the certification requirements to the Department of Health for review and incorporation into rule by January 1, 2007.

- Changes the date by which swimming instructors must comply with new certification requirements, to account for the extra time in which curriculum and requirements are developed and put into Administrative Rule.

  As amended, the bill requires that a person certified under s. 514.071 before July 1, 2006, must meet the additional certification requirements of this section by January 1, 2008. A person certified under s. 514.071 on or after July 1, 2007, must meet the additional certification requirements of this section within 6 months after receiving certification under 514.071.

On April 5, 2006 the Business Regulation Committee adopted an amendment to the bill and reported it favorably with the committee substitute. The amendment made the following changes:

- Changed the certification requirement to apply only to swimming instructors who hold themselves out to specialize in training those with developmental disabilities.

- Applied the requirement to swim instructors regardless of whether they work at a public or private pool.

This analysis reflects the bill as amended.

CHAMBER ACTION

The Business Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to certification of swimming instructors; creating s. 514.072, F.S.; requiring additional certification of swimming instructors specializing in training people who have developmental disabilities; requiring the Dan Marino Foundation, Inc., to develop certification requirements and a training curriculum and to submit the certification requirements to the Department of Health for review; providing deadlines for certification; providing a remedy for certification violations; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 514.072, Florida Statutes, is created to read:

514.072 Certification of swimming instructors for people who have developmental disabilities required.--

(1) Any person working at a swimming pool who holds himself or herself out as a swimming instructor specializing in training people who have developmental disabilities, as defined in s. 393.063(10), must be certified by the Dan Marino Foundation, Inc., in addition to being certified under s. 514.071. The Dan Marino Foundation, Inc., must develop certification requirements and a training curriculum for swimming instructors for people who have developmental disabilities and must submit the certification requirements to the Department of Health for review by January 1, 2007. A person certified under s. 514.071 before July 1, 2007, must meet the additional certification requirements of this section before January 1, 2008. A person certified under s. 514.071 on or after July 1, 2007, must meet the additional certification requirements of this section within 6 months after receiving certification under s. 514.071.

(2) In addition to any other remedies available to the department, the department may sue to enjoin the operation of any public swimming pool that uses any swimming instructor in violation of subsection (1).

Section 2. The sum of $535,000, of which $185,000 is recurring, is appropriated from the General Revenue Fund to the Department of Health for distribution to the Dan Marino Foundation, Inc., for the 2006-2007 fiscal year for the purpose of implementing this act.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1327 CS Transition Services for Adolescents and Young Adults with Disabilities
SPONSOR(S): Davis, D.
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 2288

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	6 Y, 0 N, w/CS	Preston	Collins
2) Health Care Appropriations Committee		Money	Massengale
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

The bill establishes the Jacksonville Health and Transition Services Pilot Program for the purpose of assisting adolescents and young adults with special health care, educational, or vocational needs in transitioning into the adult health care system and employment. The pilot program is to serve persons in North Central Florida, which includes residents in Baker, Clay, Duval, Nassau, and St. Johns counties. The pilot program is to be located in Children's Medical Services (CMS) in the Department of Health (DOH) for administrative purposes.

Provisions of the bill address the following:

- Require participants in the pilot program to be offered an assessment of their developmental, educational, and vocational achievement.
- Require the pilot program to work with participants and their families to plan for transition to college or to programs for adult educational and vocational rehabilitation.
- Require the pilot program to work with local educational and vocational entities to provide vocational counseling and training.
- Specify that the pilot program should develop partnerships with community agencies to support comprehensive transition planning and educational and vocational counseling services.

The bill requires specific health services, social services, and administrative services to be provided to participants by the Department of Internal Medicine at the University of Florida-Jacksonville, the Department of Pediatrics at the University of Florida-Jacksonville, the Nemours Children's Clinic, the Institute for Health, Policy, and Evaluation Research within the Duval County Health Department, and other state and local entities. Participation in the pilot by these entities is voluntary, but such participation requires the program to comply with the requirements of the bill.

The bill provides a $350,000 appropriation to CMS to fund startup and operation costs of the pilot program, and an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—The bill provides an opportunity for many private entities to participate in the development and implementation of the pilot program, which results in additional responsibilities for those groups.

Safeguard individual liberty—If individuals are able to become more self-sufficient and productive as a result of participation in the pilot, then they will have an increased ability to conduct their own affairs.

Empower families—If participants of the program are able to become more self-sufficient and supporting as adults, then their reliance on assistance from family and other sources should decrease.

B. EFFECT OF PROPOSED CHANGES:

Transitioning from Childhood and Adolescent Services to Adult Services and Employment

Children with special health care or educational needs face significant obstacles as they age out of child health care and educational service programs. Many states, universities, organizations, and health care providers are developing plans to assist youths with special health care and educational needs to successfully transition into multiple aspects of adult life.

Transitioning into adulthood is a difficult process for all adolescents, but the transition presents additional challenges for young people with health care and educational disabilities. "Transition services" is the term used to describe a set of services and supports designed to assist adolescents in adjusting to the change from the home and school environment to independent living and meaningful employment. Students with health or educational disabilities often face this transition unprepared for further vocational training, post secondary education, gainful employment, or the ability to navigate the non-pediatric health care system. Some of the barriers to a successful transition include:

- Students leaving school are often placed on a waitlist for adult services and may not be able to keep a job they obtained in school because of a lack of transitional supports as adults. Medicaid waiver rules require students to return to school for services until age 22 if they have a special education diploma.
- Youth with disabilities and their families are often poorly prepared for the transition from an entitlement program (such as a free and appropriate education, Children's Medical Services (CMS), or Medicaid) to an adult service system.
- Priorities and expectations in the systems that serve children and youth with health and educational disabilities are very different than the structure of the service and support system for adults, which is focused on integration into the community rather than separate programs that are only for people with disabilities.
- Commitment to the philosophy of self-determination and choice varies across agencies;
- Eligibility for services and supports vary by agency and often support staff and families may be unaware of services for which they are eligible because planning processes are often not coordinated.
- Social Security benefits often create a disincentive to work. Individuals on Social Security Disability Income (SSDI) who require supports and health benefits to obtain a job lose eligibility for those services if they make over $850, thus losing the benefits that enable them to obtain and keep meaningful employment.
- Agencies may have different criteria for providers of the same service.

Although there are a variety of federal and state programs and agencies with some involvement in meeting the health care, educational and vocational needs of children and adolescents transitioning into adult programs, successfully integrating these efforts has proven difficult.

Health Care Transitioning

Persons with special health care needs or disabilities are more than twice as likely to postpone needed health care because they cannot afford it. Furthermore, people with disabilities are four times more likely to have special needs that are not covered by their health insurance. True independence requires accessible and affordable health care.

However, children and adolescents with special health care needs face significant challenges in transitioning into the adult health care system. Primarily, this is because of the complexity of their health care needs and their high utilization of medical services relative to other adults. For example, according to a survey by Brandeis University and Family Voices of parents of children with special health care needs, parents reported that in the preceding year, their child needed the following services:[1]

- 82 percent needed services from specialty medical doctors.
- 49 percent needed speech therapy.
- 48 percent needed physical therapy.
- 48 percent needed occupational therapy.
- 29 percent needed home health services.
- 20 percent needed mental health services.

Currently, in Florida, there are a number of initiatives that conduct research and provide information to patients and their families on how to transition children and adolescents into the non-pediatric health care system. These initiatives include the following:

- **Health Care Transitions**—The Promising Practices in Health Care Transition Project is a research and training initiative of the Institute for Child Health Policy at the University of Florida. The website includes tools, resources, and links that deal with transition issues and how other youth and families are meeting this goal. It is also the site of a Transition Listserv that provides international communication for youth, families and professionals who would like to communicate and share ideas and resources with each other.[2]

- **The Transition Center**—The Transition Center, located at the University of Florida in Gainesville, aims to enrich the lives of students through self-advocacy, access to contacts, proper resources, and by providing an opportunity for students to interact with one another as they make decisions and discover what they want out of life. They are also a resource for family members and professionals.[3]

- **Adolescent Health Transition Project**—This website was created by the University of Washington and is housed at the Center for Human Development and Disability. The Adolescent Health Transition Project is designed to help ease the transition from pediatric to adult health care for adolescents with special health care needs. This site is a resource for information, materials, and links to other people with an interest in health transition issues.[4]

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[1] The Consortium for Children and Youth with Disabilities and Special Health Care Needs, *Children with Special Health Care Needs and Access to Health and Rehabilitative Services: A Fact Sheet on Findings*, May 2002. Found at http://www3.georgetown.edu/research/gucchd/consortium/documents/brief1.pdf

[2] See http://hctransitions.ichp.edu/

[3] See http://www.thetransitioncenter.org/page.asp?page=content/about.html&pagetype=visitor

[4] See http://depts.washington.edu/healthtr/index.html

Educational and Vocational Transitioning

Advocates for persons with disabilities emphasize that education is the key to independence and future success, is critical to obtaining work, and affects how much money an individual can earn. Before the passage of the Individuals with Disabilities Education Act (IDEA) in 1975, which granted all children with disabilities a free, appropriate public education, many children with disabilities did not attend school because the buildings or class activities were inaccessible. Even now, 22 percent of Americans with disabilities fail to graduate high school, compared to 9 percent of those without disabilities. According to the National Organization on Disability's Harris Survey of Americans with Disabilities,[5]

- Young people with disabilities drop out of high school at twice the rate of their peers.
- As many as 90 percent of children with disabilities are living at the poverty level three years after graduation.
- Eighty percent of people with significant disabilities are not working.
- Currently, only one out of ten persons with a developmental disability will achieve integrated, competitive employment, and most will earn less than $2.40 an hour in a sheltered workshop.

Recently, there have been several statewide initiatives focused on helping to identify challenges faced by young adults with disabilities as they transition from high school to adult life and to develop strategies to create an effective transition system. The state agencies involved in these interagency activities include the Agency for Persons with Disabilities, the Department of Education, the Department of Children and Family Services, the Department of Health (DOH), the Agency for Health Care Administration, and the Department of Juvenile Justice.

A variety of private organizations and individuals have also been involved in these activities, including the Able Trust, the Advocacy Center for Persons with Disabilities, Inc., the ADA Working Group, Center for Autism and Related Disabilities at the University of South Florida, Family Network on Disabilities of Florida, Inc., the Florida Developmental Disabilities Council, Inc., the Florida Independent Living Council, Inc., the Florida Institute for Family Involvement, the Florida Recreation and Parks Association, the Florida Rehabilitation Council, the Florida Schools Health Association, the Transition Center at the University of Florida, the Transition to Independence Process Project, Workforce Florida, Inc., parents, self-advocates, and teachers from throughout the state.[6]

JaxHATS: Jacksonville Health and Transition Services

The Jacksonville Health and Transition Services (JaxHATS) pilot program was created in 2005 to establish a "medical home" for all youth and young adults with chronic medical or developmental problems in Northeast Florida (Duval, Baker, Clay, Nassau and St. Johns counties). The pilot program is based at the University of Florida Shands-Jacksonville campus and has collaborative agreements with other providers such as the Nemours Children's Clinic. For Fiscal Year 2005-06, the program is funded through CMS.

Some, of the diagnostic categories covered by the JaxHATS program include: Spina Bifida; Cerebral Palsy; Muscular Dystrophies and other neuromuscular diseases; Sickle Cell Anemia; Cystic Fibrosis and other chronic lung diseases; Down's Syndrome; autism and other developmental disabilities; diabetes and other chronic endocrine disorders; congenital heart disease or heart disease acquired during childhood; chronic gastro-intestinal (GI) disease, such as Crohn's Disease, Ulcerative Collitis, Short Gut Syndrome; and immunodeficiencies.

Estimates indicate that as many as 6,000 adolescents and young adults living in North Central Florida have chronic medical or developmental conditions, as well as special needs in education. As of March

[5] The 2004 National Organization on Disability/Harris Survey of Americans with Disabilities. Found at www.nod.org
[6] Florida Partners in Transition, http://partnersintransition.org/members.htm

2006, JaxHATS served approximately 40 individuals in its pilot program. JaxHATS has several future goals for the pilot program, including:

- The establishment of a Medical Home for all youth/young adults with chronic medical or developmental problems in North Central Florida.
- The development of a reliable referral network of adult medical and surgical specialists.
- The design and implementation of a comprehensive evaluation of the proposed pilot project.
- The development of a multidisciplinary research program to formulate and integrate research in the field of medical transition and conduct studies that will establish Standards of Excellence in the field of transition.

Effects of the Bill

The bill creates the Jacksonville Health and Transition Services Pilot Program, the purpose of which is to assist adolescents and young adults with special health care, educational, or vocational needs in transitioning into the adult health care system and employment. The pilot program is located in the CMS program in DOH for administrative purposes.

The bill requires the Department of Internal Medicine and the Department of Pediatrics at the University of Florida-Jacksonville Campus to develop the pilot program in collaboration with CMS and specified community partners, including, but not limited to, the Area Association for Retarded Citizens (ARC Jacksonville), Hope Haven Clinic, the Spina Bifida Association, and the Down Syndrome Association. The primary care clinic for the pilot program will be located in the Ambulatory Care Center on the Shands-Jacksonville Hospital campus. Participation in the pilot by these entities is voluntary, but such participation requires the program to comply with the requirements of the bill.

The target population for the pilot program includes disabled persons who are 14 through 25 years of age; reside in the North Central area of CMS; have chronic health-related or developmental conditions; and could benefit from the program. All children in the CMS State Child Health Insurance Program (SCHIP), Medicaid, and Safety Net (CMS), as well as referrals from the Nemours Children's Clinic, the Duval County School District, general pediatricians, and other health care providers, should be assessed for eligibility to enroll in the program.

Participants in the pilot program must be offered an assessment of their developmental, educational, and vocational achievement. The pilot program must work with participants and their families to plan for transition to college or to programs for adult educational and vocational rehabilitation. The pilot program must work with local educational and vocational entities to provide vocational counseling and training. The pilot program should develop partnerships with the community agencies listed above to support comprehensive transition planning and educational and vocational counseling services.

The pilot program shall include the following:

- A primary-care clinic in the University of Florida-Jacksonville Adult Ambulatory Care Center, which shall be staffed by a multidisciplinary team that includes a pediatrician and an internist, a nurse care coordinator, a transition specialist, and an insurance specialists.
- A network of adult medical and surgical specialists in the community and from the University of Florida-Jacksonville System who agree to treat the special needs of the program's participants.
- Comprehensive intake-evaluation and transition-planning services for participants which cover health care planning, assessment of educational needs, vocational preparation, referral to habilitative support services, assistance in securing insurance, and coordination of services across these areas.

- Coordination and collaboration with other agencies that are involved in providing services to adolescents and young adults who have special health care needs, including the ARC of Jacksonville, Hope Haven Clinic, Nemours Children's Clinic, the Duval County School District, the juvenile justice system, family support services, the foster care program of the Department of Children and Families Services, faith-based community programs, and the Duval County Health Department.
- Ongoing evaluation of patient satisfaction, disease self-management, and success in taking steps toward employment and health-related quality of life and other health-related outcomes.
- Services that support the intellectual development and educational and vocational preparation of program participants.

Specified health services, educational and vocational services, and administrative services must be provided to participants by the Department of Internal Medicine at the University of Florida-Jacksonville, the Department of Pediatrics at the University of Florida-Jacksonville, the Nemours Children's Clinic, the Institute for Health, Policy, and Evaluation Research within the Duval County Health Department, and other state and local entities.

C. SECTION DIRECTORY:

Section 1. Creates an unnumbered section of Florida Statute relating to the creation of the Jacksonville Health and Transition Services Pilot Program.

Section 2. Provides for a $350,000 appropriation from General Revenue to Children's Medical Services to implement the provisions of the bill.

Section 3. Provides for an effective date of July 1, 2006

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill contains a $350,000 appropriation from the General Revenue Fund to CMS for the purpose of paying start-up and operation costs of the pilot program during the 2006-07 fiscal year. However, there are no estimates for the cost of services that must be provided under the pilot program by school districts, university medical schools, local county health departments, community colleges, technical and vocational schools, the Department of Juvenile Justice, the Department of Children and Families Services, and the Vocational Rehabilitation Agency.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The pilot program creates a number of administrative and service requirements for nonprofit agencies and health care providers who choose to participate. While CMS is provided an appropriation for initial start-up costs to administer the pilot program, there is no specific appropriation for the activities required in the bill for private and non-profit entities. Although the exact amount is indeterminate at this time, it is estimated that substantial resources would be necessary to implement the provisions of the bill in the private sector.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 4, 2006, the Future of Florida's Families Committee adopted one amendment to the bill that provides for the pilot to develop collaborative partnerships with the public and private entities specified in the bill to implement and administer the pilot. Any entity that participates in the pilot is voluntary, but any entity that participates must comply with the requirements of the bill.

The bill was reported favorably as committee substitute.

CHAMBER ACTION

The Future of Florida's Families Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to transition services for adolescents and young adults with disabilities; creating the Jacksonville Health and Transition Services Pilot Program; assigning the program for administrative purposes to the Children's Medical Services program in the Department of Health; providing purposes of the pilot program; providing for the development of collaborative partnerships with certain entities; delineating the target population; describing participating service providers and the services that they are to provide; providing for the design and implementation of a comprehensive evaluation of the pilot program; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Jacksonville Health and Transition Services Pilot Program; creation; purposes; participating agencies and services provided; evaluation.--

(1) The Jacksonville Health and Transition Services Pilot Program is created for the purpose of assisting adolescents and young adults who have special needs relating to health care and educational and vocational services in making a smooth transition from the child health care and educational system to the adult health care system and to employment. For administrative purposes, the pilot program is located in the Children's Medical Services program in the Department of Health.

(2) The pilot program, in consultation with the Children's Medical Services program in the Department of Health, shall develop collaborative partnerships with the public and private entities specified in this section to administer and implement the pilot program. Participation in the program by such entities is voluntary. However, an entity that participates in the program must comply with the requirements of this section.

(3) The Department of Internal Medicine and the Department of Pediatrics at the University of Florida Jacksonville, in collaboration with Children's Medical Services and community partners, including, but not limited to, ARC Jacksonville, Hope Haven Children's Clinic and Family Center, the Spina Bifida Association, and the Down Syndrome Association, shall develop the pilot program. The primary care clinic for the program shall be located in the Ambulatory Care Center on the University of Florida/Shands Jacksonville campus.

(4) The target population for the pilot program comprises adolescents and young adults with disabilities who are between 14 and 25 years of age, inclusive, reside in the North Central area of Children's Medical Services of the Department of Health, have chronic health-related or developmental conditions, and could benefit from such a program. All children in the Children's Medical Services State Child Health Insurance Program (SCHIP), Medicaid, and Safety Net (Children's Medical Services), as well as referrals from the Nemours Children's Clinic, the Duval County School District, general pediatricians, and other health care providers, shall be assessed for eligibility to enroll in the program.

(5) Upon intake into the program, participants shall be offered an assessment of their development and educational and vocational achievement. The pilot program shall work with participants and their families to plan for transition to college or to programs for adult educational and vocational rehabilitation. The program shall work with local school systems, community colleges, technical centers, and community-based agencies to provide vocational counseling and training. The pilot program shall develop partnerships with community-based agencies as listed in subsection (3) to support comprehensive transition planning and educational and vocational counseling services.

(6) The pilot program shall include:

(a) A primary-care clinic in the Ambulatory Care Center on the University of Florida/Shands Jacksonville campus, which shall be staffed by a multidisciplinary team that includes a

pediatrician and an internist, a nurse care coordinator, a transition specialist, and insurance specialists.

(b) A network of adult medical and surgical specialists from the community and from the University of Florida Jacksonville Health Care System who agree to treat the special needs of the adolescents and young adults who are being served in the pilot program.

(c) Comprehensive intake-evaluation and transition-planning services for adolescents and young adults and their families that cover health care planning, assessment of educational needs, vocational preparation, referral to habilitative support services, assistance in securing insurance, and coordination of services across these areas.

(d) Coordination and collaboration with other agencies that are involved in providing services to adolescents and young adults who have special health care needs, including ARC Jacksonville, Hope Haven Children's Clinic and Family Center, Nemours Children's Clinic, the Duval County School District, the juvenile justice system, family support services, the foster care program of the Department of Children and Family Services, faith-based community programs, and the Duval County Health Department.

(e) Ongoing evaluation of patient satisfaction, disease self-management, and success in taking steps toward employment and health-related quality of life and other health-related outcomes.

(f) Services that support the intellectual development and educational and vocational preparation of adolescents and young adults with disabilities who are enrolled in the program.

(7) Participating agencies and the health and social services that they shall provide include:

(a) The Department of Internal Medicine at the University of Florida Jacksonville, which shall:

1. Provide a primary care physician who shall serve as the co-medical director of the pilot program.

2. Work with both medical and surgical specialty services to facilitate specialty referrals of patients.

3. Provide administrative support to the pilot program, including, but not limited to, supervision of clinic staff, scheduling, and billing.

4. Allot clinic space for a multidisciplinary transition clinic, which shall initially operate at least once a week and shall expand as the demand increases.

5. Assign nursing and support staff to the clinic, including staff to implement an appointment system.

6. Maintain medical records and charts under the University of Florida/Shands Health Care System.

7. Make efforts to ensure that adolescents and young adults with disabilities participating in the pilot program, regardless of their funding source, shall continue to receive health care services, including primary and specialty outpatient medical services, medications, and laboratory services, until they reach their 26th birthday.

(b) The Department of Pediatrics at the University of Florida Jacksonville, which shall:

1. Provide a primary care pediatrician who shall serve as the co-medical director of the pilot program.

2. Work with pediatric specialty physicians to facilitate the transfer of adolescents and young adults with disabilities from pediatric health care specialists to adult health care specialists. The Department of Pediatrics shall contact pediatric specialists and determine what activities or supports are needed to transfer patients from pediatric specialty care to adult specialty care, such as the transfer of medical records and the provision of educational programs for adult specialists.

3. Encourage participation by the subspecialty pediatric physicians through the development of transition programs within each specialty area to prepare patients and their families for participation in the pilot program.

4. Identify and refer adolescents and young adults and their families who are candidates for the pilot program.

(c) The Nemours Children's Clinic, which shall:

1. Encourage participation by the subspecialty pediatric physicians through the development of transition programs within each specialty area to prepare adolescents and young adults with disabilities and their families for participation in the pilot program.

2. Identify and refer adolescents and young adults and their families who are candidates for the pilot program.

3. Provide in-kind support for care coordination and specialized transitional services.

(d) The Institute for Health, Policy and Evaluation Research within the Duval County Health Department, which shall provide the design and implementation of a comprehensive evaluation of the pilot program that includes an assessment of the service-oriented process and patient and family-oriented outcome measures. The Institute for Health, Policy and Evaluation Research shall also conduct a longitudinal study to determine whether the adolescents and young adults with disabilities who participate in this pilot program are more successful than the adolescents and young adults with disabilities who are not associated with the program but receive assistance with vocational rehabilitation only.

(e) Hope Haven Children's Clinic and Family Center, Nemours Children's Clinic, ARC Jacksonville, the Duval County School District, the Florida Community College of Jacksonville, the Division of Vocational Rehabilitation of the Department of Education, and other groups, which shall develop a comprehensive educational and vocational transition program that shall be offered to adolescents and young adults with disabilities in the program. The transition specialists in these agencies shall identify, to the greatest extent feasible, all adolescents and young adults with disabilities in the district and refer them to the program.

Section 2. The sum of $350,000 is appropriated from the General Revenue Fund to Children's Medical Services in the Department of Health for the purpose of paying startup and operation costs of the Jacksonville Health and Transition Services Pilot Program during the 2006-2007 fiscal year.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1365 CS Florida Healthy Kids Corporation Act
SPONSOR(S): Davis, M. and others
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 2050

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	6 Y, 0 N, w/CS	Davis	Collins
2) Health Care Appropriations Committee		Speir WRS	Massengale
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1365 does the following:

- Allows illegal and legal aliens to participate in the Florida KidCare Program.
- Allows the children of state employees to participate in the Florida KidCare Program.
- Repeals the local match requirement for non-Title XXI children.
- Directs the Agency for Health Care Administration (AHCA) to pursue a federal waiver to increase the financial eligibility threshold for Title XXI premium assistance to up to 300 percent of the federal poverty level (FPL) guidelines.
- Allows health and dental plans participating in the Florida Healthy Kids Program to market the program.
- Allows the Florida Healthy Kids Corporation to release certain information concerning a child's application to parents or legal guardians of the child.

The fiscal impact of this bill is $55.6 million ($28 million General Revenue) in Fiscal Year 2006-2007 and $59.8 million ($30.4 million General Revenue) in Fiscal Year 2007-2008.

The bill shall take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government and Promote Personal Responsibility—The bill expands eligibility for state-subsidized health care coverage.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP), enacted as part of the Balanced Budget Act of 1997, created Title XXI of the Social Security Act, which provides insurance to uninsured children in low-income families either through a Medicaid expansion, a separate children's health program, or a combination of both. SCHIP was designed as a federal/state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid.

Congress set aside approximately $40 billion over 10 years (1998 through 2007) for states to expand health insurance coverage for millions of children. Under SCHIP, the federal government provides a capped amount of funds to states on a matching basis. For the 2005-2006 fiscal year, the federal allocation is $249,329,871 and the federal matching rate is 71.22 percent.

To be eligible for coverage under Title XXI, a child must meet certain eligibility guidelines. The guidelines require the child to meet the following criteria:

- In a household with an income at or below 200 percent of the FLP guidelines ($40,000 for a family of four in 2006).
- Between the ages of birth through age 18.
- Not the dependant of a state employee eligible for state benefits.
- A U.S. citizen or qualified alien.
- Not an inmate of a public institution or patient in an institution for mental diseases.
- Not eligible for Medicaid.

The Florida KidCare Program

The statutory framework for KidCare is delineated in s. 409.810 through 409.821, F.S. KidCare has four components each with its own eligibility standards:

- Medicaid:
  - Birth to age 1, with family incomes up to 200 percent of the FPL guidelines.
  - Ages 1 through 5, with family incomes up to 133 percent of the FPL guidelines.
  - Ages 6 through 18, with family incomes up to 100 percent of the FPL guidelines.
  - Ages 19 through 20, with family incomes up to 24 percent of the FPL guidelines.

- Medikids:
  - Children ages 1 through 4 with family incomes above 133 percent up to 200 percent of the FPL guidelines.

- Healthy Kids:
  - Children age 5, with family incomes above 133 percent up to 200 percent of the FPL guidelines.
  - Children age 6 through 18, with family incomes above 100 percent up to 200 percent of the FPL guidelines.
  - A limited number of children who have family incomes above 200 percent of the FPL guidelines are enrolled in the unsubsidized full-pay option in which the family pays the entire cost of the premium, including administrative costs.

- Children's Medical Services (CMS) Network:
  - Children ages birth through age 18 who have serious health care problems. For Title XXI-funded eligible children with special health care needs, the CMS Network receives a capitation payment from the Agency for Health Care Administration to provide services for them. For children who do not qualify for Title XIX- or Title XXI- funded coverage, services are limited and subject to the availability of funds.

2006 Federal Poverty Level Guidelines

Persons in Family or Household	100%	200%
1	$ 9,800	19,600
2	13,200	26,400
3	16,600	33,200
4	20,000	40,000
5	23,400	46,800

The Agency for Health Care Administration (AHCA) administers Medicaid and Medikids. AHCA is also the lead state agency for the federally funded portion of the KidCare Program. The Florida Healthy Kids Corporation (FHKC), pursuant to a contract with AHCA, administers the Healthy Kids component. FHKC's responsibilities include eligibility determination, collection of premiums, contracting with authorized insurers, and the development of benefit packages. CMS is under the Department of Health and administers the CMS Network. For Title XXI-funded children with special health care needs, the CMS Network receives a capitated payment from the Agency for Health Care Administration of approximately $518.00 per child, per month.

Section 409.814(5), F.S., allows a child whose family income is above 200 percent of the FPL guidelines or a child that is not eligible for premium assistance as delineated in statute[1] to participate in KidCare, except Medicaid, if the family pays the full premium without any premium assistance. These children are known as "full-pays." Only Healthy Kids has enrolled full-pays. The Healthy Kids full-pay premium is $110 per child per month. Current law limits the participation of full-pays to no more than 10 percent of total enrollees in the Florida Healthy Kids program to avoid adverse selection.[2]

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[1]Section 409.814(4), F.S., also excludes from premium assistance under KidCare the following children unless they are eligible for Medicaid:
(a) A child who is eligible for coverage under a state health benefit plan on the basis of a family member's employment with a public agency in the state.
(b) A child who is currently eligible for or covered under a family member's group health benefit plan or under other employer health insurance coverage, excluding coverage provided under the Florida Healthy Kids Corporation as established under s. 624.91, provided that the cost of the child's participation is not greater than 5 percent of the family's income. This provision shall be applied during redetermination for children who were enrolled prior to July 1, 2004. These enrollees shall have 6 months of eligibility following redetermination to allow for a transition to the other health benefit plan.
(c) A child who is seeking premium assistance for the Florida KidCare program through employer-sponsored group coverage, if the child has been covered by the same employer's group coverage during the 6 months prior to the family's submitting an application for determination of eligibility under the program.
(d) A child who is an alien, but who does not meet the definition of qualified alien, in the United States.
(e) A child who is an inmate of a public institution or a patient in an institution for mental diseases.
(f) A child who has had his or her coverage in an employer-sponsored health benefit plan voluntarily canceled in the last 6 months, except those children who were on the waiting list prior to March 12, 2004.
(g) A child who is otherwise eligible for KidCare and who has a preexisting condition that prevents coverage under another insurance plan as described in paragraph (b) which would have disqualified the child for KidCare if the child were able to enroll in the plan shall be eligible for KidCare coverage when enrollment is possible.

[2] Adverse selection occurs when too many children who are likely to incur high medical costs join the same health insurance plan. Adverse selection can cause what insurers refer to as a "death spiral." As more sick children join, the health insurance plan must raise premiums to cover cost. As

Section 624.91(3), F.S., establishes eligibility criteria for state-funded premium assistance in the Healthy Kids program. The following categories are eligible for state-funded premium assistance:

- Residents of Florida who are eligible for the Florida KidCare program pursuant to s. 409.814, F.S.
- Legal aliens, who were enrolled in the Healthy Kids program as of January 31, 2004, and who, because of their alien status, that is, are not "qualified aliens," do not qualify for Title XXI federal funds.
- Individuals who turned 19 as of March 31, 2004, who were receiving Healthy Kids coverage prior to the enactment of the Florida KidCare program. This provision is repealed March 31, 2005.
- Dependents of state employees who were enrolled in the Healthy Kids program as of January 31, 2004. Such dependents remained eligible until January 1, 2005.

Legislative Commission on Migrant and Seasonal Labor

Originally established in 1970, the Legislative Commission on Migrant and Seasonal Labor (the commission) is responsible for identifying issues, improving conditions and reducing problems affecting migrant and seasonal workers and their families pursuant to s. 450.201, F.S. The commission was somewhat inactive until 2004, when the Legislature renamed the commission and required it to produce a report to the Legislature by February 1 of each year, beginning in 2006.

The commission began meeting in October 2005, to create a forum for discussions of issues of concern to migrant and seasonal laborers and their dependents. The commission heard from various stakeholders with an interest in migrant and seasonal labor issues, including advocacy groups, agriculture industry representatives, state agency personnel, and the farm workers themselves.

Health care for the children of migrant and seasonal laborers surfaced as a topic of major concern. The commission recommended the funding of KidCare benefits for all children of migrant and seasonal laborers. This bill attempts to implement that recommendation by making alien children eligible to participate in KidCare.

Federal State Children's Health Insurance Program (SCHIP) Waivers

Federal law sets Title XXI income eligibility at 200 percent of the FPL guidelines. As SCHIP evolved and grew, a new option became available to the states to expand coverage under the program. Since 2000, the federal government allows states to apply for waivers of the income eligibility threshold so they can increase eligibility over 200 percent of the FPL guidelines. The specific authority is a research and demonstration project waiver, authorized by Section 1115 of the Social Security Act, also known as a "Section 1115 waiver." This authority allows the secretary of Health and Human Services to waive certain provisions in the legislation of some "grant-in-aid" programs such as Medicaid—and now SCHIP—to authorize a pilot or demonstration project aimed at promoting the objectives of the program. It also allows the secretary to provide matching funds where such funds normally are not available.

The Centers for Medicare and Medicaid Services (CMS), released the Section 1115 waiver guidance for SCHIP to states on July 31, 2000. The guidance describes factors to be considered in granting states permission to implement state-devised approaches that ordinarily are not permitted under the SCHIP law in order to meet programmatic goals and objectives and still receive an enhanced match rate. CMS examines the overall state approach instead of basing its decision solely on the criteria

provided in the guidance. These demonstration projects can be used to research an issue of interest to CMS, to test a program, or to otherwise fulfill a research purpose. Section 1115 demonstration projects are given five years in which to prove their research and public policy value. The demonstration projects must contain specific objectives and an evaluation component.

Most importantly from a fiscal perspective, all state activities under SCHIP 1115 waivers must be "budget neutral." In the case of SCHIP, this means "allotment neutrality," that is, a state cannot exceed its individual SCHIP funds allotment. Reallocated funds from previously unspent SCHIP allotments do not count toward the available amount. Rules on budget neutrality and funding differ somewhat between SCHIP Medicaid expansions and SCHIP state-designed programs. In the case of Medicaid expansion 1115 waivers, a state could receive funds from a Medicaid amendment or waiver should its SCHIP allotment run out. If an SCHIP demonstration waiver is operated under an SCHIP state-designed program, no more federal funds are available once SCHIP funds are exhausted. Three possible options are generally possible for an SCHIP demonstration waiver. It can expand benefits and services; expand coverage to new populations; or both.

Expanded services and benefits can be provided to discrete populations as long as these services do not substitute for existing services funded by state or federal money. The two types of additional services are: supplemental services and public health initiatives.

New populations—such as parents of eligible children, pregnant women and children age 18 to 21 otherwise eligible for SCHIP—could be covered under a SCHIP 1115 demonstration waiver. Adults with no children and who are not pregnant will not be considered an eligible population for demonstration projects. Other demonstration waivers that CMS has said it would consider are the following:

- Extending coverage for children who become ineligible for SCHIP because of their age while in treatment for a specific condition.
- Proposals to promote enrollment of children eligible for other programs such as the free and reduced school lunch program and the Healthy Start program.

Effect

The bill amends s. 409.811, F.S., adding a definition of "Healthy Kids" as a component of the Florida KidCare program of medical assistance for children 5 through 18 years of age as authorized under s. 624.91, F.S., and administered by the Florida Healthy Kids Corporation. The bill adds a definition of the "maximum income threshold" as a percentage of the current FPL guidelines used to determine eligibility for certain program components, as approved by federal waiver or an amendment to the state plan.

The bill amends s. 409.8132, F.S., changing the set income eligibility from 200 percent of the FPL guidelines to the maximum income threshold and changing a reference to the Health Care Financing Administration to the Centers for Medicare and Medicaid Services.

Year-round open enrollment is conditioned on the Social Service Estimating Conference determining that state and federal funds are sufficient to fund the increased enrollment through federal fiscal year 2007 when SCHIP is scheduled to sunset under federal law. This bill amends s. 409.8134, F.S., removing references to federal and state funding and removing a reference to funding through 2007.

The bill amends s. 409.814, F.S., to change the income eligibility ceiling from 200 percent of the FPL to the maximum income threshold. Section 409.814, F.S., is also amended to allow alien children, both illegal and legal, and children of state employees to participate in KidCare.

The bill requires AHCA to seek approval from CMS for a waiver to increase the income eligibility ceiling to 300 percent of the FPL guidelines. Until the waiver is approved, the maximum income threshold used for the Florida KidCare program shall be 200 percent of the FPL or the highest income threshold allowed under current federal law. Any such expansion under this subsection is subject to a specified appropriation.

The bill amends s. 409.821, F.S., clarifying that FHKC may release certain information concerning a child's application to parents or legal guardians of the child.

The bill amends s. 624.91, F.S., revising eligibility for nonfederal premium assistance in the Florida Healthy Kids program.

The largest category affected under the bill would be legal aliens who do not qualify for Title XXI federal funds because of their alien status, according to AHCA representatives. By removing the current qualification that these children had to have been enrolled in Healthy Kids prior to January 31, 2004, the bill would allow children who have moved to Florida since February 1, 2004, or have become uninsured, the opportunity to receive Healthy Kids coverage. Also, children from families with incomes within 200 percent of the FPL guidelines, but who do not meet all of the other technical eligibility factors, would be able to apply for subsidized state coverage.

FHKC is currently required to establish a local match policy for the enrollment of non-Title XXI children in the Florida Healthy Kids program. At minimum the local match must equal what is required in the General Appropriations Act. The bill repeals the requirement for local match for non-Title XXI children.

The bill allows participating health and dental plans to develop marketing and other promotional materials and participate in activities, such as health fairs and public events, as approved by FHKC.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.811, F.S., adding a definition of "Healthy Kids"; and a definition of the "maximum income threshold."

Section 2. Amends s. 409.8132, F.S., changing the set income eligibility from 200 percent of the FPL guidelines to the maximum income threshold; inserting a cross reference; and changing a reference to the Health Care Financing Administration to the Centers for Medicare and Medicaid Services.

Section 3. Amends s. 409.8134, F.S., removing references to federal and state funding and removing a reference to funding through 2007.

Section 4. Amends s. 409.814, F.S., changing the set income eligibility from 200 percent of the FPL guidelines to the maximum income threshold; specifying groups that are not eligible for federal premium assistance; and specifying children that are eligible for nonfederal premium assistance.

Section 5. Amends s. 409.816, F.S., correcting a cross reference.

Section 6. Amends s. 409.818, F.S., requiring AHCA to seek a federal waiver to increase the income eligibility ceiling.

Section 7. Amends s. 409.821, F.S., clarifying that FHKC may release certain information concerning a child's application to parents or legal guardians of the child.

Section 8. Amends s. 624.91, F.S., revising eligibility for nonfederal premium assistance in the Florida Healthy Kids program; repealing the requirement for local match for nonfederal premium assistance; allowing participating health and dental plans to market and promote.

Section 9. The bill takes effect July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

Recurring Expenditures	2006-2007	2007-2008
General Revenue Fund	$28,084,800	$30,422,980
Grants and Donations Trust Fund	$ 4,517,440	$ 4,517,440
Medical Care Trust Fund	$22,957,864	$24,884,658
Total Funds	$55,560,104	$59,825,078

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments section.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Non-Title XXI children not currently in the Florida Healthy Kids program would benefit under the provisions of this bill because such children could receive benefits under the program.

Health and dental plan providers would receive economic benefit from increased enrollment in their plans.

D. FISCAL COMMENTS:

The expenditures estimate above presumes that the caseload for non-Title XXI children will increase by 13,703 children and that the Legislature will provide an appropriation for these children. Since these children do not receive federal match, the state will have to appropriate general revenue to pay for their health benefits. It is estimated that the cost of the health and dental benefits and administrative costs for these children will be $18.8 million in Fiscal Year 2006-2007 and $20.3 million in Fiscal Year 2007-2008.

The expenditure estimate above presumes the federal waiver will be approved. Currently, there are 25,347 full-pay children whose family income is below 300 percent of the FPL guidelines participating in the Florida Healthy Kids program. It is presumed that all these children will be covered by the waiver and the cost of their benefits will be picked up by the state and federal government. The cost to the state is presumed to be $9.3 million for Fiscal Year 2006-2007 and $10 million for Fiscal Year 2007-2008. This estimate is probably low because there are more children with family incomes between 200 percent and 300 percent of the FPL guidelines than just those currently participating as full-pays.

Local governments currently contribute to the premium cost to purchase benefits for non-Title XXI children. The proviso in the General Appropriations Act for the current year requires a local match of $7 million. This bill removes the requirement that local governments contribute to the premium cost to purchase benefits for non-Title XXI children.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not provide rulemaking authority to FHKC.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 5, 2006, the Future of Florida's Families committee adopted a Committee Substitute to House Bill 1365. The substantive changes made in the committee substitute include changing provisions related to the maximum income threshold in the Florida KidCare program and revising provisions relating to the Healthy Kid Corporation. The bill analysis reflects these changes.

CHAMBER ACTION

The Future of Florida's Families Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the Florida KidCare program; amending s. 409.811, F.S.; defining the terms "Healthy Kids" and "maximum income threshold"; amending s. 409.8132, F.S.; providing that eligibility for the Florida KidCare program be at or below the maximum income threshold rather than a specified percentage of the federal poverty level; conforming and updating references; amending s. 409.8134, F.S.; conforming provisions to changes made by the act; amending s. 409.814, F.S.; requiring that eligibility for the Florida KidCare program be at or below the maximum income threshold rather than a specified percentage of the federal poverty level; providing that certain specified children are eligible for nonfederal premium assistance for health insurance; providing that a child whose family income is above the maximum income threshold may participate in the Florida KidCare program but is subject to certain conditions; amending s. 409.816, F.S.;

conforming a cross-reference; amending s. 409.818, F.S.; requiring the Agency for Health Care Administration to seek approval from the federal Centers for Medicare and Medicaid Services to use the highest maximum income threshold allowed by federal law or regulation, which is up to 300 percent of the most recently stated federal poverty limit; providing an alternative eligibility standard pending approval of the request; amending s. 409.821, F.S., relating to a public-records exemption; specifying that such provision does not prohibit an enrollee's parent or legal guardian from obtaining confirmation of coverage and dates of coverage; amending s. 624.91, F.S.; conforming provisions to changes made by the act; revising the powers of the Florida Healthy Kids Corporation; authorizing participating health and dental plans to develop marketing and other promotional materials and to participate in activities to promote the Florida Healthy Kids Corporation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.811, Florida Statutes, is amended to read:

409.811 Definitions relating to Florida KidCare Act.--As used in ss. 409.810-409.820, the term:

(1) "Actuarially equivalent" means that:

(a) The aggregate value of the benefits included in health benefits coverage is equal to the value of the benefits in the benchmark benefit plan; and

(b) The benefits included in health benefits coverage are substantially similar to the benefits included in the benchmark benefit plan, except that preventive health services must be the same as in the benchmark benefit plan.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Applicant" means a parent or guardian of a child or a child whose disability of nonage has been removed under chapter 743, who applies for determination of eligibility for health benefits coverage under ss. 409.810-409.820.

(4) "Benchmark benefit plan" means the form and level of health benefits coverage established in s. 409.815.

(5) "Child" means any person under 19 years of age.

(6) "Child with special health care needs" means a child whose serious or chronic physical or developmental condition requires extensive preventive and maintenance care beyond that required by typically healthy children. Health care utilization by such a child exceeds the statistically expected usage of the normal child adjusted for chronological age, and such a child often needs complex care requiring multiple providers, rehabilitation services, and specialized equipment in a number of different settings.

(7) "Children's Medical Services Network" or "network" means a statewide managed care service system as defined in s. 391.021(1).

(8) "Community rate" means a method used to develop premiums for a health insurance plan that spreads financial risk across a large population and allows adjustments only for age, gender, family composition, and geographic area.

(9) "Department" means the Department of Health.

(10) "Enrollee" means a child who has been determined eligible for and is receiving coverage under ss. 409.810-409.820.

(11) "Enrollment ceiling" means the maximum number of children receiving premium assistance payments, excluding children enrolled in Medicaid, that may be enrolled at any time in the Florida KidCare program. The maximum number shall be established annually in the General Appropriations Act or by general law.

(12) "Family" means the group or the individuals whose income is considered in determining eligibility for the Florida KidCare program. The family includes a child with a custodial parent or caretaker relative who resides in the same house or living unit or, in the case of a child whose disability of nonage has been removed under chapter 743, the child. The family may also include other individuals whose income and resources are considered in whole or in part in determining eligibility of the child.

(13) "Family income" means cash received at periodic intervals from any source, such as wages, benefits, contributions, or rental property. Income also may include any money that would have been counted as income under the Aid to

Families with Dependent Children (AFDC) state plan in effect prior to August 22, 1996.

(14) "Florida KidCare program," "KidCare program," or "program" means the health benefits program administered through ss. 409.810-409.820.

(15) "Guarantee issue" means that health benefits coverage must be offered to an individual regardless of the individual's health status, preexisting condition, or claims history.

(16) "Health benefits coverage" means protection that provides payment of benefits for covered health care services or that otherwise provides, either directly or through arrangements with other persons, covered health care services on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(17) "Health insurance plan" means health benefits coverage under the following:

(a) A health plan offered by any certified health maintenance organization or authorized health insurer, except a plan that is limited to the following: a limited benefit, specified disease, or specified accident; hospital indemnity; accident only; limited benefit convalescent care; Medicare supplement; credit disability; dental; vision; long-term care; disability income; coverage issued as a supplement to another health plan; workers' compensation liability or other insurance; or motor vehicle medical payment only; or

(b) An employee welfare benefit plan that includes health benefits established under the Employee Retirement Income Security Act of 1974, as amended.

(18) "Healthy Kids" means a component of the Florida KidCare program of medical assistance for children 5 through 18 years of age as authorized under s. 624.91 and administered by the Florida Healthy Kids Corporation.

(19) "Maximum income threshold" means a percentage of the current federal poverty level used to determine eligibility for certain program components, as approved by federal waiver or an amendment to the state plan.

(20) ~~(18)~~ "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and ss. 409.901-409.920, as administered in this state by the agency.

(21) ~~(19)~~ "Medically necessary" means the use of any medical treatment, service, equipment, or supply necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity and which is:

(a) Consistent with the symptom, diagnosis, and treatment of the enrollee's condition;

(b) Provided in accordance with generally accepted standards of medical practice;

(c) Not primarily intended for the convenience of the enrollee, the enrollee's family, or the health care provider;

(d) The most appropriate level of supply or service for the diagnosis and treatment of the enrollee's condition; and

(e) Approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the enrollee's condition.

(22) ~~(20)~~ "Medikids" means a component of the Florida KidCare program of medical assistance authorized by ~~Title XXI of the Social Security Act, and regulations thereunder, and~~ s. 409.8132, as administered in the state by the agency.

(23) ~~(21)~~ "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(24) ~~(22)~~ "Premium" means the entire cost of a health insurance plan, including the administration fee or the risk assumption charge.

(25) ~~(23)~~ "Premium assistance payment" means the monthly consideration paid by the agency per enrollee in the Florida KidCare program towards health insurance premiums.

(26) ~~(24)~~ "Qualified alien" means an alien as defined in s. 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.

(27) ~~(25)~~ "Resident" means a United States citizen, or qualified alien, who is domiciled in this state.

(28) ~~(26)~~ "Rural county" means a county having a population density of less than 100 persons per square mile, or a county defined by the most recent United States Census as rural, in

which there is no prepaid health plan participating in the Medicaid program as of July 1, 1998.

(29) ~~(27)~~ "Substantially similar" means that, with respect to additional services as defined in s. 2103(c)(2) of Title XXI of the Social Security Act, these services must have an actuarial value equal to at least 75 percent of the actuarial value of the coverage for that service in the benchmark benefit plan and, with respect to the basic services as defined in s. 2103(c)(1) of Title XXI of the Social Security Act, these services must be the same as the services in the benchmark benefit plan.

Section 2. Subsections (6) and (7) of section 409.8132, Florida Statutes, are amended to read:

409.8132 Medikids program component.--

(6) ELIGIBILITY.--

(a) A child who has attained the age of 1 year but who is under the age of 5 years is eligible to enroll in the Medikids program component of the Florida KidCare program, if the child is a member of a family that has a family income which exceeds the Medicaid applicable income level as specified in s. 409.903, but which is equal to or below the maximum income threshold ~~200 percent of the current federal poverty level~~. In determining the eligibility of ~~such~~ a child, an assets test is not required. A child who is eligible for Medikids may elect to enroll in Florida Healthy Kids coverage or employer-sponsored group coverage. However, a child who is eligible for Medikids may participate in the Florida Healthy Kids program only if the child has a sibling participating in the Florida Healthy Kids

program and the child's county of residence permits such enrollment.

(b) The provisions of s. 409.814(3), (4), ~~and~~ (5), and (6) are ~~shall be~~ applicable to the Medikids program.

(7) ENROLLMENT.--Enrollment in the Medikids program component may occur at any time throughout the year. A child may not receive services under the Medikids program until the child is enrolled in a managed care plan or MediPass. Once determined eligible, an applicant may receive choice counseling and select a managed care plan or MediPass. The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's voluntary choice period ends. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients and only if the federal Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~ determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act.

Section 3. Subsection (2) of section 409.8134, Florida Statutes, is amended to read:

409.8134 Program enrollment and expenditure ceilings.--

(2) The Florida KidCare program may conduct enrollment at any time throughout the year for the purpose of enrolling children eligible for all program components listed in s. 409.813 except Medicaid. The four Florida KidCare administrators shall work together to ensure that the year-round enrollment period is announced statewide. Eligible children shall be

enrolled on a first-come, first-served basis using the date the enrollment application is received. Enrollment shall immediately cease when the enrollment ceiling is reached. Year-round enrollment shall only be held if the Social Services Estimating Conference determines that sufficient ~~federal and state~~ funds will be available to finance the increased enrollment ~~through federal fiscal year 2007~~. Any individual who is not enrolled must reapply by submitting a new application. The application for the Florida KidCare program is ~~shall be~~ valid for a period of 120 days after the date it was received. At the end of the 120-day period, if the applicant has not been enrolled in the program, the application is ~~shall be~~ invalid and the applicant shall be notified of the action. The applicant may resubmit the application after notification of the action taken by the program. Except for the Medicaid program, whenever the Social Services Estimating Conference determines that there are presently, or will be by the end of the current fiscal year, insufficient funds to finance the current or projected enrollment in the Florida KidCare program, all additional enrollment must cease and additional enrollment may not resume until sufficient funds are available to finance the ~~such~~ enrollment.

Section 4. Section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.--A child who has not reached 19 years of age whose family income is equal to or below the maximum income threshold ~~200 percent of the federal poverty level~~ is eligible for the Florida KidCare program as provided in this

section. For enrollment in the Children's Medical Services Network, a complete application includes the medical or behavioral health screening. If, subsequently, an individual is determined to be ineligible for coverage, he or she must immediately be disenrolled from the respective Florida KidCare program component.

(1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be enrolled in Medicaid and is not eligible to receive health benefits under any other health benefits coverage authorized under the Florida KidCare program.

(2) A child who is not eligible for Medicaid, but who is eligible for the Florida KidCare program, may obtain health benefits coverage under any of the other components listed in s. 409.813 if such coverage is approved and available in the county in which the child resides. However, a child who is eligible for Medikids may participate in the Florida Healthy Kids program only if the child has a sibling participating in the Florida Healthy Kids program and the child's county of residence permits such enrollment.

(3) A child who is eligible for the Florida KidCare program who is a child with special health care needs, as determined through a medical or behavioral screening instrument, is eligible for health benefits coverage from and shall be referred to the Children's Medical Services Network.

(4) The following children are not eligible to receive federal premium assistance for health benefits coverage under the Florida KidCare program, except under Medicaid if the child

would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(a) A child who is eligible for coverage under a state health benefit plan on the basis of a family member's employment with a public agency in the state.

(b) A child who is currently eligible for or covered under a family member's group health benefit plan or under other employer health insurance coverage, excluding coverage provided under the Florida Healthy Kids Corporation as established under s. 624.91, provided that the cost of the child's participation is not greater than 5 percent of the family's income. This provision shall be applied during redetermination for children who were enrolled prior to July 1, 2004. These enrollees shall have 6 months of eligibility following redetermination to allow for a transition to the other health benefit plan.

(c) A child who is seeking premium assistance for the Florida KidCare program through employer-sponsored group coverage, if the child has been covered by the same employer's group coverage during the 6 months prior to the family's submitting an application for determination of eligibility under the program.

(d) A child who is an alien, but who does not meet the definition of qualified alien, in the United States.

(e) A child who is an inmate of a public institution or a patient in an institution for mental diseases.

(f) A child who has had his or her coverage in an employer-sponsored health benefit plan voluntarily canceled in

the last 6 months, except those children who were on the waiting list prior to March 12, 2004.

(g) A child who is otherwise eligible for KidCare and who has a preexisting condition that prevents coverage under another insurance plan as described in paragraph (b) which would have disqualified the child for KidCare if the child were able to enroll in the plan shall be eligible for KidCare coverage when enrollment is possible.

(5) Subject to a specific appropriation for this purpose, the following children are eligible to receive nonfederal premium assistance for health benefits coverage under the Florida KidCare program, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(a) A child who is eligible for coverage under a state health benefit plan on the basis of a family member's employment with a public agency in the state.

(b) A child who is an alien in the United States but who does not meet the definition of qualified alien.

(6) ~~(5)~~ A child whose family income is above the maximum income threshold ~~200 percent of the federal poverty level~~ or a child who is excluded under the provisions of subsection (4) may participate in the Florida KidCare program, excluding the Medicaid program, but is subject to the following provisions:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the premium, including any administrative costs.

(b) The agency is authorized to place limits on enrollment in Medikids by these children in order to avoid adverse selection. The number of children participating in Medikids whose family income exceeds the maximum income threshold ~~200 percent of the federal poverty level~~ must not exceed 10 percent of total enrollees in the Medikids program.

(c) The board of directors of the Florida Healthy Kids Corporation is authorized to place limits on enrollment of these children in order to avoid adverse selection. In addition, the board is authorized to offer a reduced benefit package to these children in order to limit program costs for such families. The number of children participating in the Florida Healthy Kids program whose family income exceeds the maximum income threshold ~~200 percent of the federal poverty level~~ must not exceed 10 percent of total enrollees in the Florida Healthy Kids program.

(d) Children described in this subsection are not counted in the annual enrollment ceiling for the Florida KidCare program.

(7) ~~(6)~~ Once a child is enrolled in the Florida KidCare program, the child is eligible for coverage under the program for 12 months without a redetermination or reverification of eligibility, if the family continues to pay the applicable premium. Eligibility for program components funded through Title XXI of the Social Security Act shall terminate when a child attains the age of 19. Effective January 1, 1999, a child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for

12 months without a redetermination or reverification of eligibility.

(8) ~~(7)~~ When determining or reviewing a child's eligibility under the Florida KidCare program, the applicant shall be provided with reasonable notice of changes in eligibility which may affect enrollment in one or more of the program components. When a transition from one program component to another is authorized, there shall be cooperation between the program components and the affected family which promotes continuity of health care coverage. Any authorized transfers must be managed within the program's overall appropriated or authorized levels of funding. Each component of the program shall establish a reserve to ensure that transfers between components will be accomplished within current year appropriations. These reserves shall be reviewed by each convening of the Social Services Estimating Conference to determine the adequacy of such reserves to meet actual experience.

(9) ~~(8)~~ In determining the eligibility of a child, an assets test is not required. Each applicant shall provide written documentation during the application process and the redetermination process, including, but not limited to, the following:

(a) Proof of family income, which must include a copy of the applicant's most recent federal income tax return. In the absence of a federal income tax return, an applicant may submit wages and earnings statements (pay stubs), W-2 forms, or other appropriate documents.

(b) A statement from all family members that:

1. Their employer does not sponsor a health benefit plan for employees; or

2. The potential enrollee is not covered by the employer-sponsored health benefit plan because the potential enrollee is not eligible for coverage, or, if the potential enrollee is eligible but not covered, a statement of the cost to enroll the potential enrollee in the employer-sponsored health benefit plan.

(10) ~~(9)~~ Subject to paragraph (4)(b) and s. 624.91(3), the Florida KidCare program shall withhold benefits from an enrollee if the program obtains evidence that the enrollee is no longer eligible, submitted incorrect or fraudulent information in order to establish eligibility, or failed to provide verification of eligibility. The applicant or enrollee shall be notified that because of such evidence program benefits will be withheld unless the applicant or enrollee contacts a designated representative of the program by a specified date, which must be within 10 days after the date of notice, to discuss and resolve the matter. The program shall make every effort to resolve the matter within a timeframe that will not cause benefits to be withheld from an eligible enrollee.

(11) ~~(10)~~ The following individuals may be subject to prosecution in accordance with s. 414.39:

(a) An applicant obtaining or attempting to obtain benefits for a potential enrollee under the Florida KidCare program when the applicant knows or should have known the potential enrollee does not qualify for the Florida KidCare program.

(b) An individual who assists an applicant in obtaining or attempting to obtain benefits for a potential enrollee under the Florida KidCare program when the individual knows or should have known the potential enrollee does not qualify for the Florida KidCare program.

Section 5. Subsection (3) of section 409.816, Florida Statutes, is amended to read:

409.816 Limitations on premiums and cost-sharing.--The following limitations on premiums and cost-sharing are established for the program.

(3) Enrollees in families with a family income above 150 percent of the federal poverty level, who are not receiving coverage under the Medicaid program or who are not eligible under s. 409.814(6) ~~s. 409.814(5)~~, may be required to pay enrollment fees, premiums, copayments, deductibles, coinsurance, or similar charges on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all children in a family may not exceed 5 percent of the family's income. However, copayments, deductibles, coinsurance, or similar charges may not be imposed for preventive services, including well-baby and well-child care, age-appropriate immunizations, and routine hearing and vision screenings.

Section 6. Subsection (3) of section 409.818, Florida Statutes, is amended to read:

409.818 Administration.--In order to implement ss. 409.810-409.820, the following agencies shall have the following duties:

(3) The Agency for Health Care Administration, under the authority granted in s. 409.914(1), shall:

(a) Calculate the premium assistance payment necessary to comply with the premium and cost-sharing limitations specified in s. 409.816. The premium assistance payment for each enrollee in a health insurance plan participating in the Florida Healthy Kids Corporation shall equal the premium approved by the Florida Healthy Kids Corporation and the Office of Insurance Regulation of the Financial Services Commission pursuant to ss. 627.410 and 641.31, less any enrollee's share of the premium established within the limitations specified in s. 409.816. The premium assistance payment for each enrollee in an employer-sponsored health insurance plan approved under ss. 409.810-409.820 shall equal the premium for the plan adjusted for any benchmark benefit plan actuarial equivalent benefit rider approved by the Office of Insurance Regulation pursuant to ss. 627.410 and 641.31, less any enrollee's share of the premium established within the limitations specified in s. 409.816. In calculating the premium assistance payment levels for children with family coverage, the agency shall set the premium assistance payment levels for each child proportionately to the total cost of family coverage.

(b) Annually calculate the program enrollment ceiling based on estimated per child premium assistance payments and the estimated appropriation available for the program.

(c) Make premium assistance payments to health insurance plans on a periodic basis. The agency may use its Medicaid fiscal agent or a contracted third-party administrator in making

these payments. The agency may require health insurance plans that participate in the Medikids program or employer-sponsored group health insurance to collect premium payments from an enrollee's family. Participating health insurance plans shall report premium payments collected on behalf of enrollees in the program to the agency in accordance with a schedule established by the agency.

(d) Monitor compliance with quality assurance and access standards developed under s. 409.820.

(e) Establish a mechanism for investigating and resolving complaints and grievances from program applicants, enrollees, and health benefits coverage providers, and maintain a record of complaints and confirmed problems. In the case of a child who is enrolled in a health maintenance organization, the agency must use the provisions of s. 641.511 to address grievance reporting and resolution requirements.

(f) Approve health benefits coverage for participation in the program, following certification by the Office of Insurance Regulation under subsection (4).

(g) Adopt rules necessary for calculating premium assistance payment levels, calculating the program enrollment ceiling, making premium assistance payments, monitoring access and quality assurance standards, investigating and resolving complaints and grievances, administering the Medikids program, and approving health benefits coverage.

The agency is designated the lead state agency for Title XXI of the Social Security Act for purposes of receipt of federal

funds, for reporting purposes, and for ensuring compliance with federal and state regulations and rules. The agency shall seek approval from the federal Centers for Medicare and Medicaid Services for the highest maximum income threshold of up to 300 percent of the most recently stated federal poverty limit. Until the federal agency approves the request, the maximum income threshold used for the Florida KidCare program shall be 200 percent of the most recently stated federal poverty limit or the highest income threshold allowed under current federal law. Any such expansion under this subsection is subject to a specified appropriation for such purpose.

Section 7. Section 409.821, Florida Statutes, is amended to read:

409.821 Florida KidCare program public records exemption.--Notwithstanding any other law to the contrary, any information identifying a Florida KidCare program applicant or enrollee, as defined in s. 409.811, held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such information may be disclosed to another governmental entity only if disclosure is necessary for the entity to perform its duties and responsibilities under the Florida KidCare program and shall be disclosed to the Department of Revenue for purposes of administering the state Title IV-D program. The receiving governmental entity must maintain the confidential and exempt status of such information. Furthermore, such information may

not be released to any person without the written consent of the program applicant. This exemption applies to any information identifying a Florida KidCare program applicant or enrollee held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation before, on, or after the effective date of this exemption. A violation of this section is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. This section does not prohibit an enrollee's parent or legal guardian from obtaining confirmation of coverage and dates of coverage.

Section 8. Subsections (3) and (5) of section 624.91, Florida Statutes, are amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(3) ELIGIBILITY FOR NONFEDERAL ~~STATE FUNDED~~ ASSISTANCE.--Only residents of this state between 5 and 18 years of age who meet the qualifications for the Florida KidCare program under s. 409.814 are eligible for nonfederal assistance in the Florida Healthy Kids program. ~~the following individuals are eligible for state funded assistance in paying Florida Healthy Kids premiums:~~

~~(a) Residents of this state who are eligible for the Florida KidCare program pursuant to s. 409.814.~~

~~(b) Notwithstanding s. 409.814, legal aliens who are enrolled in the Florida Healthy Kids program as of January 31, 2004, who do not qualify for Title XXI federal funds because they are not qualified aliens as defined in s. 409.811.~~

~~(c) Notwithstanding s. 409.814, individuals who have attained the age of 19 as of March 31, 2004, who were receiving Florida Healthy Kids benefits prior to the enactment of the Florida KidCare program. This paragraph shall be repealed March 31, 2005.~~

~~(d) Notwithstanding s. 409.814, state employee dependents who were enrolled in the Florida Healthy Kids program as of January 31, 2004. Such individuals shall remain eligible until January 1, 2005.~~

(5) CORPORATION AUTHORIZATION, DUTIES, PROMOTION, POWERS.--

(a) There is created the Florida Healthy Kids Corporation, a not-for-profit corporation.

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

~~2. Arrange for the collection of any voluntary contributions to provide for payment of premiums for children who are not eligible for medical assistance under Title XXI of the Social Security Act. Each fiscal year, the corporation shall establish a local match policy for the enrollment of non Title-XXI-eligible children in the Healthy Kids program. By May 1 of each year, the corporation shall provide written notification of the amount to be remitted to the corporation for the following fiscal year under that policy. Local match sources may include,~~

~~but are not limited to, funds provided by municipalities, counties, school boards, hospitals, health care providers, charitable organizations, special taxing districts, and private organizations. The minimum local match cash contributions required each fiscal year and local match credits shall be determined by the General Appropriations Act. The corporation shall calculate a county's local match rate based upon that county's percentage of the state's total non Title XXI expenditures as reported in the corporation's most recently audited financial statement. In awarding the local match credits, the corporation may consider factors including, but not limited to, population density, per capita income, and existing child health related expenditures and services.~~

2.~~3.~~ Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional coverage in contributing counties under Title XXI.

3.~~4.~~ Establish the administrative and accounting procedures for the operation of the corporation.

4.~~5.~~ Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that the ~~such~~ standards for rural areas do ~~shall~~ not limit primary care providers to board-certified pediatricians.

5.~~6.~~ Determine eligibility for children seeking to participate in the ~~Title XXI funded components of the~~ Florida

KidCare program consistent with the requirements specified in s. 409.814~~, as well as the non-Title XXI eligible children as provided in subsection (3)~~.

6.~~7.~~ Establish procedures under which ~~providers of local match to,~~ applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.

7.~~8.~~ Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

8.~~9.~~ Establish enrollment criteria that ~~which shall~~ include penalties or waiting periods of not fewer than 60 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums.

9.~~10.~~ Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent.

For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

~~11. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.~~

10.~~12.~~ Develop and implement a plan to publicize the Florida Healthy Kids Corporation, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program. Participating health and dental plans may develop marketing and other promotional materials and participate in activities, such as health fairs and public events, as approved by the corporation. The health and dental plans may also contact their enrollees and former enrollees to encourage continued participation in the plan.

11.~~13.~~ Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation.

12.~~14.~~ Provide a report annually to the Governor, Chief Financial Officer, Commissioner of Education, Senate President,

Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives.

13.~~15.~~ Establish benefit packages which conform to the provisions of the Florida KidCare program, as created in ss. 409.810-409.820.

(c) Coverage under the corporation's program is secondary to any other available private coverage held by, or applicable to, the participant child or family member. Insurers under contract with the corporation are the payors of last resort and must coordinate benefits with any other third-party payor that may be liable for the participant's medical care.

(d) The Florida Healthy Kids Corporation shall be a private corporation not for profit, organized under ~~pursuant to~~ chapter 617, and shall have all powers necessary to carry out the purposes of this act, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this section ~~act~~.

Section 9. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1409 Florida Health Information Network, Inc.
SPONSOR(S): Benson
TIED BILLS: HB 1411 **IDEN./SIM. BILLS:** SB 2786

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N	Bell	Mitchell
2) Health Care Appropriations Committee		Speir WFS	Massengale
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1409 creates the "Florida Health Information Network Act" as a public/private partnership that will implement a statewide electronic medical records network.

The bill establishes the Florida Health Information Network, Inc., as a not-for-profit corporation. The corporation will be managed by an uncompensated board of directors. The initial board will consist of the current Governor's Health Information Infrastructure Advisory Board (for 18 months).

The primary duties of the Florida Health Information Network, Inc., are to oversee, coordinate, and implement a statewide electronic medical records network. Among the many duties listed in the enabling legislation, the Florida Health Information Network, Inc., is charged with development of technical standards for electronic medical records and recruiting participants into the network.

The Agency for Health Care Administration (agency) will provide oversight of the Florida Health Information Network, Inc.

The bill appropriates $9,426,117 from the General Revenue Fund to the agency to carry out the Florida Health Information Network Act.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The bill creates the Florida Health Information Network, Inc. as a not for profit corporation. The fiscal impact of the bill is $9,426,117 in year one.

Empower Families/Safeguard Individual Liberty—Full implementation of electronic medical records may increase individual's access to their own health care information, provide more transparency in the health care system, and increase the quality of care.

Maintain Public Security—Full implementation of electronic medical records would better prepare the state for natural or manmade disasters, such as hurricanes.

B. EFFECT OF PROPOSED CHANGES:

Executive Order Number 04-93 created the Governor's Health Information Infrastructure Advisory Board (board) on May 4, 2004. The Executive Order states that the board shall be "advisory in nature." The board is to advise the Agency for Health Care Administration (agency) in creating a health information infrastructure. The board is to continue in existence until June 30, 2007 or all of its objectives are achieved. The Executive Order named W. Michael Heekin as Chair of the Board.

In collaboration with the agency, the board established the Florida Health Information Network, Inc., as a Florida not-for-profit corporation. The Articles of Incorporation were filed on April 5, 2005, and named W. Michael Heekin as the initial director and officer. The Articles of Incorporation states that the directors are to appointed or elected "per executive order 04-93."

The 2005 Legislature appropriated $1.5 million to AHCA for the Florida Health Information Network subject to Legislative Budget Commission approval. The initial budget amendment request from AHCA sought $250,000 for start-up funds for the creation of the Florida Health Information Network, Inc. The amendment was changed to have all $1.5 million fund grants.

The budget amendment providing for the funding of grants for the Florida Health Information Network was approved by the Legislative Budget Commission on October 20, 2005. The grants program provides grants for the planning and implementation of local and regional health information exchange projects and for technical assistance programs to encourage the adoption of electronic health record systems by physicians and other practitioners. Nine (9) grant projects were awarded during the period January through June 30, 2006. These include five planning grants, three implementation grants and one technical assistance grant. Final reports on the projects are due to the agency July 10, 2006.

House Bill 1409 creates s. 408.064, F.S., establishing the "Florida Health Information Network Act" to promote statewide integration of electronic medical records. It creates the Florida Health Information Network, Inc., as a not-for-profit corporation that will be managed by an uncompensated board of directors. The initial board of directors will consist of the current Governor's Health Information Infrastructure Advisory Board for 18 months.

The primary duty of the Florida Health Information Network, Inc., is to develop a statewide health information network. To accomplish this end, the Florida Health Information Network, Inc., is directed in its enabling legislation to:

- Devise and implement a strategic plan for infrastructure development, and periodically evaluate and modify the plan.
- Develop, operate, and maintain the technical infrastructure necessary to perform the functions of the network consistent with the strategic plan.
- Promote an integrated approach to efforts to create a secure network for communication of electronic health information in the state.
- Market the network to promote widespread use.
- Assist in the development and expansion of existing local or regional health information networks and the creation of new networks.
- Develop annual budgets.
- Take commercially reasonable measures to protect its intellectual property, including obtaining patents, trademarks, and copyrights where appropriate.
- Make recommendations for reform of the state's laws regarding medical records.

The Florida Health Information Network, Inc., is also charged with developing and enforcing privacy, security, operational, and technical standards among regional and local health information networks.

The bill requires the Florida Health Information Network, Inc., to regularly assess the adoption of electronic records systems and utilization of the statewide network, and incorporate the results into its regular strategic planning process.

The Agency for Heath Care Administration (agency) is responsible for promoting the development of the health information network as a public-private partnership in the state. The agency is also responsible for developing and implementing a plan for the formation and operation of the health information network.

Pursuant to House Bill 1409, AHCA will contract with the Florida Health Information Network, Inc., to implement the plan, July 1, 2006, through June 30, 2008.

The effective date of the bill is July 1, 2006.

C. SECTION DIRECTORY:

Section 1. Creates s. 408.064, F.S., establishing the Florida Health Information Network, Inc., as a not-for-profit corporation.

Section 2. Provides an appropriation.

Section 3. Provides that the bill will take effect July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

Expenditures:

Non-recurring	2006-2007
General Revenue	$9,426,117
Total	$9,426,117

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

According to the Agency for Health Care Administration (agency), the fiscal impact of the bill is $9,426,117 for the first year. This amount includes $9,426,117 for the agency to contract with the Florida Health Information Network, Inc., to carry out the purposes of the act. The contract will provide $5,953,200 for the health information network technical infrastructure, $1,524,452 for technical staff and technical consulting, $1,052,446 for professional and administrative personnel and overhead, and $896,019 for practitioner outreach projects and a public education campaign. The agency expects an additional $9,426,117 appropriation in year two.

The long-term impacts of electronic medical records are estimated to create more efficiency in the health care system and improve patient safety. Researchers estimate that nationwide implementation of electronic medical records could eventually save more than $81 billion annually.[1]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration has the necessary rulemaking authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[1] Health Affairs, 24, no. 5 (2005): 1103-1117.

A bill to be entitled

An act relating to the Florida Health Information Network, Inc.; creating s. 408.064, F.S.; providing a short title and purpose; requiring the Agency for Health Care Administration to develop and implement a plan for the formation and operation of a health information network; requiring the agency to enter into a contract to implement the plan; creating the Florida Health Information Network, Inc., as a not-for-profit corporation; providing for a board of directors and for terms thereof; providing duties and responsibilities of the corporation; requiring a report to the Governor and Legislature; providing an appropriation; providing an effective date.

WHEREAS, the cost of health care in Florida has grown substantially while the demand for a more coordinated system of health care has increased, and

WHEREAS, with the benefit of an effective system for sharing privacy-protected medical information among authorized health care stakeholders, health care providers and consumers, aided by computerized tools that automatically analyze available health information and by combining that data with clinical logic and practice guidelines based on current, sound medical science, will have access to the medical information needed to make sound decisions about health care, and

WHEREAS, the state's health care system would benefit from a reduction in the time it takes to evaluate promising medical techniques, devices, and drugs and to bring the products and

procedures that are proven safe and effective to the health care marketplace more quickly, and

WHEREAS, the state's public health officers require effective information systems to detect, monitor, and manage emerging health threats most efficiently, and

WHEREAS, a successful medical response to large-scale disasters such as hurricanes is enhanced by effective and timely access to the medical records of those needing medical care, and

WHEREAS, providing consumers with effective access to their personal health information and computerized tools that gather data from their medical records and assist in interpreting and monitoring the data in partnership with their health care providers would permit consumers to become better informed and more proactive in managing their health and wellness, thereby reducing utilization of and adding efficiencies to the health care system, and

WHEREAS, it is feasible and advisable for the state to implement an effective integrated health information network capable of drawing together critical health information from multiple sources and presenting that information to authorized parties in a usable format to support sound decisions about health care by providers, consumers, public health officers, and researchers while ensuring the privacy and security of personal health information, and

WHEREAS, studies have shown that health information networks are more likely to succeed if they are developed, implemented, and operated by a neutral manager with broad support among health care stakeholders, and

WHEREAS, the Legislature declares that an integrated health information network is a necessary and important part of effectively addressing the challenges and opportunities facing the state's health care delivery system, and it is the policy of the state to promote the development and implementation of an integrated statewide health information network to be operated by a neutral manager as a public-private partnership, with reasonable oversight and regulation by the state to promote the safety, security, and integrity of the health information network, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 408.064, Florida Statutes, is created to read:

408.064 Florida Health Information Network Act; purpose; duties.--

(1) This section may be cited as the "Florida Health Information Network Act."

(2) The purpose of this section is to promote the establishment of a privacy-protected and secure integrated statewide network for the communication of electronic health information among authorized parties and to foster a coordinated public-private initiative for the development and operation of Florida's health information infrastructure.

(3) The agency is responsible for promoting the development of a health information network as a public-private partnership among the state's providers, payors, consumers,

employers, public health officials, medical researchers, and other health care stakeholders. The agency shall develop and implement a plan for the formation and operation of a health information network and shall contract with the Florida Health Information Network, Inc., for the purpose of implementing the plan, in conformity with the legislative intent expressed in this section, for the period July 1, 2006, through June 30, 2008.

(4) There is created a not-for-profit corporation, to be known as the "Florida Health Information Network, Inc.," which shall be registered, incorporated, organized, and operated in compliance with chapter 617, and which shall not be a unit or agency of state government. The affairs of the not-for-profit corporation shall be managed by a board of directors who shall serve without compensation. The initial board of directors shall be the Governor's Health Information Infrastructure Advisory Board which shall serve a term of 18 months. Upon expiration of the terms of the initial members, members shall be appointed to 4-year staggered terms in accordance with s. 20.052 by majority vote as provided in the bylaws of the corporation. Any vacancy in office shall be filled for the remainder of the term by majority vote of the members. Any member may be reappointed.

(5) The Florida Health Information Network, Inc., shall:

(a) Institute a statewide health information network in the state by:

1. Devising and implementing a strategic plan for infrastructure development and periodically evaluating and modifying that plan.

2. Developing, operating, and maintaining the technical infrastructure necessary to perform the functions of the network consistent with the strategic plan.

3. Promoting an integrated approach to efforts to create a secure network for communication of electronic health information in the state.

4. Marketing the network to promote widespread use of the network.

5. Assisting in the development and expansion of existing local or regional health information networks and the creation of new networks.

(b) Develop and implement specific programs or strategies that address the creation, development, and expansion of regional or local health information networks and the recruitment of participants in the network.

(c) Specify standards among regional and local health information networks and other participants in the Florida Health Information Network, Inc., to promote effective statewide and interstate interoperability.

(d) Regularly assess the adoption of electronic health records systems and utilization of the statewide network by providers, consumers, public health officers, and other health care stakeholders to identify and regularly reevaluate the state's health information infrastructure strengths and weaknesses, assess opportunities to increase consumer access to the consumer's health records, and incorporate such information into its regular strategic planning process.

(e) Develop and enforce privacy, security, operational, and technical standards among regional and local health information networks to ensure effective statewide privacy, data security, efficiency, and interoperability across the network. The network's standards shall be guided by reference to widely adopted standards or standards accepted by recognized national standard-setting organizations.

(f) Develop annual budgets that include funding from public and private entities, including user fees.

(g) Take commercially reasonable measures to protect its intellectual property, including obtaining patents, trademarks, and copyrights where appropriate.

(h) Make recommendations for reform of the state's laws regarding medical records.

(6) The agency shall review the data gathered about the Florida Health Information Network, Inc., pursuant to paragraph (5)(d) and make recommendations for its continued development in a report to be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 1, 2007.

Section 2. The sum of $9,426,117 is appropriated from the General Revenue Fund to the Agency for Health Care Administration for the 2006-2007 fiscal year to carry out the purposes of this act.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7139 PCB HCG 06-01 Emergency Management
SPONSOR(S): Health Care General Committee; Harrell
TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/CS/CS/SB 1058

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care General Committee	10 Y, 0 N	Ciccone	Brown-Barrios
1) Health Care Appropriations Committee		Massengale	Massengale
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 7139 amends various sections of Florida Statutes relating to the planning and operation of special needs emergency shelters in Florida. Specifically, the bill addresses emergency planning and management to enhance the safety and well-being of persons with special needs before, during and after a disaster. The bill assigns lead responsibility regarding special needs shelter maintenance and operation to certain state agencies, establishes the multi-agency special needs shelter discharge planning team and encourages coordination of emergency services among national, state and local agencies and volunteer organizations.

The bill assigns lead agency education, communication and outreach responsibilities to the Department of Community Affairs, expands special needs registration efforts, revises the membership and role of the Special Needs Interagency Committee and amplifies the Department of Health's role in establishing a more coordinated comprehensive emergency plan review of certain facilities and providers with the Department of Elder Affairs and the Agency for Health Care Administration.

The bill provides procedures to address the needs of families of special needs shelter residents, provides facility and provider reimbursement when rendering services during a disaster, authorizes certain facilities to exceed their licensed capacity during an evacuation situation, and requires the Agency for Health Care Administration to monitor and assist nursing homes during a disaster and to publish an emergency phone number for nursing requesting assistance.

The Department of Health estimates the additional responsibilities associated with the increase in comprehensive emergency management plan reviews to require $2.7 million in initial funding. The Department of Community Affairs, the Department of Elder Affairs, and the Agency for Health Care Administration, should be able to carry out the provision of the bill within existing resources. Certain provisions of the bill are conditional upon funding.

The bill provides for an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The bill adds responsibilities to the Department of Health's role in establishing a more coordinated comprehensive emergency plan review of certain facilities and providers with the Department of Elder Affairs and the Agency for Health Care Administration.

Promote Personal Responsibility and Empower Families—Providing time and appropriate pre- and post-disaster information and improving the availability of services should enable the state's residents to make choices that will enhance the safety and well-being of themselves and their families.

B. EFFECT OF PROPOSED CHANGES:

Proposed Changes

The bill amends certain sections of chapter 252, F. S., and other chapters addressing pre- and post-disaster planning to address services to persons with special needs before, during and after disasters. The bill assigns lead responsibility for certain functions to specific state agencies and establishes a multi-agency emergency special needs shelter discharge planning team to assist local areas impacted by natural or manmade disasters that require the use of special needs shelters. The bill also provides certain pre- and post disaster facility use and licensure flexibility. The effect of these provisions should be to provide increased coordination among federal, state and local entities and to facilitate the timely and appropriate use of facilities to serve the special needs population.

The bill provides the following:

- Includes individuals with cognitive impairments among persons considered to have special needs.
- Expands the communication and outreach efforts regarding special needs registration.
- Requires year-round maintenance of the special needs registry.
- Provides local law enforcement agencies with access to shelter registration information.
- Designates the Department of Community Affairs as the lead agency responsible for community education and outreach and requires the department to coordinate with certain other entities in those efforts.
- Provides that a special needs shelter is considered a public facility when activated for a disaster and as such must allow people with disabilities to bring their service animals into the facility.
- Authorizes the Department of Agriculture and Consumer Services to serve as the lead agency responsible for pet and animal sheltering during a disaster.
- Designates Children's Medical Services as the lead agency for coordinating local medical and health care providers for the staffing and management of pediatric special needs shelters.
- Authorizes the Agency for Health Care Administration to monitor nursing homes during emergencies to determine if assistance is needed and that the agency publishes an emergency telephone number for nursing homes to use.
- Specifies that the Division of Emergency Management include special needs shelter assessment, location, estimated need, and other information in its statewide emergency shelter plan.
- Requires the Department of Health to assist the Division of Emergency Management in determining the estimated need for special needs shelter space and the adequacy of the facility to meet the needs of those seeking shelter.
- Requires the Division of Emergency Management to include information regarding the availability of pet friendly shelters in the statewide emergency shelter plan.

- Requires the local emergency management agency to inspect a facility to determine its readiness prior to activating such facility.
- Assigns the county health departments, in conjunction with the local emergency management agencies, the lead responsibility to coordinate and recruit health care practitioners to staff local special needs shelters, and encourages coordination of non-medical staffing and operating of special needs shelters.
- Requires local emergency management agencies to be responsible for the designation and operation and closure of facilities and that these services and activities are coordinated with county health departments.
- Establishes state employee roles under certain circumstances in a disaster response.
- Establishes a multi-agency emergency special needs shelter discharge planning team.
- Directs the Department of Elder Affairs to convene the multi-agency special needs shelter discharge planning team as necessary to assist local areas impacted by emergency or disaster.
- Allows certain practitioners, hospitals, nursing homes or receiving facilities to request reimbursement for sheltering persons with special needs.
- Provides protections against duplication of reimbursements to receiving facilities.
- Revises the duties and membership of the Special Needs Shelter Interagency Committee and expands the committee to include the Florida Association of Aging Services Providers, the Florida Renal Coalition and AARP.
- Requires the Department of Health to adopt rules.
- Authorizes the Department of Health to solicit pre-planning event participation.
- Requires emergency management plans to address home health agency, nurse registry, hospice, and home medical equipment provider's functional staffing plan for shelters to ensure continuity of care and services for clients.
- Provides that home health agencies, nurse registries, hospice and home medical equipment providers include a continuity of care component in their respective comprehensive emergency management plans, encourages these entities to establish links to emergency operations centers to determine a mechanism to approach disaster areas to reach clients, provides for a more coordinated review of such plans by the county health departments and allows sanctioning capability by the Agency for Health Care Administration under certain circumstances.
- Provides licensure and use flexibility to allow nursing homes, assisted living facilities, and other residential care facilities to exceed their licensed bed capacity to act as a receiving facility in accordance with emergency operations plans.

Current Situation

Florida's geographical location makes this state vulnerable to a variety of natural disasters. Various state agencies coordinate with local and federal governments, interstate organizations, and the private sector to prepare residents and visitors before disasters to help protect them during such events and assist with recovery afterward.

Florida's regulatory guidelines regarding disaster response are outlined in several documents. Chapter 252, F.S., mandates the development of the Florida Comprehensive Emergency Management Plan. The plan establishes the framework to ensure that Florida is prepared to deal with the aftermath of any one of several hazards that threaten our communities, businesses, and the environment. The plan coordinates response and recovery activities with federal, state, local, and volunteer entities and organizations to unify the efforts of these groups to ensure a comprehensive approach to reducing and mitigating the effects of an emergency or disaster.

Additionally, laws relating to health care providers, including ancillary services, provide that certain rules be developed and enforced to establish reasonable and consistent quality of care to persons prior, during and after a disaster.

A significant number of Florida's citizens are considered vulnerable in the event of natural disasters such as hurricanes:

- More than 76 percent of Florida's total population (12,816,041 persons) resides in the 35 coastal counties.
- Eight percent of the state's total population (1,333,969 persons) resides in mobile homes.
- More than 18 percent of the state's total population (3,051,453 persons) is 65 years of age or older, with the highest number in Miami-Dade (314,497), Palm Beach (278,868), Broward (315,470), Pinellas (229,763) and Hillsborough (139,341) counties.[1]
- Florida has made significant strides in reducing the deficit of safe hurricane shelter space in the past five years. Approximately 50 percent of the deficit has been eliminated. Between 2004 and 2009, however, the vulnerable population in Florida is projected to increase by nearly 900,000 with as many as 16 percent possibly seeking safety in public shelters.[2]
- There are 746 nursing homes with 81,986 licensed beds in the state.
- There are an estimated 333,492 citizens that may be considered "frail elderly" (about 2 percent of the Florida's population).

Special needs shelters provide refuge to persons who because of a health or medical condition require the supervision of a health care professional during a disaster or emergency. These shelters operate and coordinate services with state, local agency and volunteer organizations. The Department of Health is the primary agency under the Emergency Support Function-8 operations to maintain and staff special needs shelters.[3] On September 1, 2004, the Governor issued Executive Order Number 04-192, authorizing the Department of Health to assume responsibility for special needs shelter operations if specifically requested by any county director of emergency management. This order, incorporated in subsequent hurricane executive orders, was prompted by, "(T)he recognition that the system was overwhelmed and that the department was in the best position, under the circumstances to assume expedient responsibility for SpNs operations..."

The Department of Health, in its 2004 Hurricane Season *AFTER ACTION REPORT*, documents that changing demographics have resulted in increasing numbers of elderly and disabled individuals receiving in-home services. The reports states, "(D)uring these storms, Florida, with its high proportion of elderly, experienced the effects of these combinations of factors like never before. Individuals, who functioned well in their homes during normal times, many with support services from home health care agencies, were unable to maintain that level of functionality during and after the storms. Storm-related disruptions to communications, transportation, power supplies, and lack of continuity of in-home support services as well as structural damage to their homes, forced many seniors out of their independent living status and into SpNS, at least temporarily. In some areas, those who had not evacuated prior to the storm found they could not safely remain in their homes after the storm due to these disruptions resulting in a 'second wave' of evacuees entering special needs shelters."[4]

The department's report underscored a number of issues and lessons learned including:

- County health departments were not always involved with other government entities in selecting SpNS.
- Many eligible persons were not aware of the Special Needs Registry and many of those registered did not actually choose to shelter in SpNS.
- Many eligible persons asked to be added to the registry just prior to storm landfall and many registry lists were not updated.
- Better asset assignment was needed, including staff with current specialty skill sets and specialized equipment such as heavy patient lift devices or able-bodied staff, respiratory therapists, oxygen concentrators and other medical support equipment.

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[1] *Comprehensive Emergency Management Plan 2004*, February 1, 2004

[2] *State of Florida 2004 Statewide Emergency Shelter Plan*, February 2004.

[3] The Florida House of Representatives, Interim Project Report, Health Care General Committee, November 2005

[4] Florida Department of Health, 2004 Hurricane Season *AFTER ACTION REPORT*, March 4, 2005.

- Lack of air conditioning and marginal food and water supplies created stressful shelter conditions.
- More coordinated discharge planning was needed.

Further, during the 2005 hurricane season, additional analysis revealed that physically impaired individuals who decided to shelter at home in multi-story buildings became "trapped" when elevators were rendered inoperable due to power outages. These individuals represent a substantial group that may also seek SpNS services in the future.

C. SECTION DIRECTORY:

Section 1. Amends s. 252.355, F.S., regarding public shelter space and special needs registration.

Section 2. Creates s. 252.3568, F.S., regarding emergency pet sheltering.

Section 3. Creates s. 252.357, F.S., regarding monitoring of nursing homes during a disaster.

Section 4. Amends s. 252.385, F.S., regarding public shelter space, statewide shelter survey and need information included in the statewide emergency shelter plan, space allocation within a shelter, shelter location, adequacy of facilities, pet friendly shelters, inspection, shelter readiness and coordination of shelter services.

Section 5. Amends s. 381.0303, F.S., regarding operation, maintenance and closure of special needs shelters; assignment and coordination of local and state agency lead responsibilities; coordination of medical and non-medical staffing in special needs shelters; designation, operation and infrastructure of special needs shelters; state employees' disaster response roles; the Department of Elder Affairs' convening of the multi-agency special needs shelter discharge planning team; health care practitioner and other emergency personnel reimbursement; hospitals, nursing and other facilities reimbursement for disaster-incurred expenses; special needs shelter interagency committee membership and responsibilities; the Department of Health's rule-making authority; pre-event planning activities, and home health agency, nurse registry, hospice and home medical equipment provider emergency management plan review.

Section 6. Amends, s. 400.492, F.S., regarding home health agencies and the provision of services during an emergency; provides that home health agencies may establish links to local emergency operations centers and provides sanctioning ability by the Agency for Health Care Administration.

Section 7. Amends s. 400.497, F.S., regarding rules establishing minimum standards; establishes county health department procedures regarding the review of home health agencies comprehensive emergency plans, provides for notification of plan approval or deficiency, and provides that the Agency for Health Care Administration may impose a fine under certain circumstances.

Section 8. Amends s. 400.506, F.S., regarding nurse registries and the provision of services during an emergency; provides that nurse registries may establish links to local emergency operations centers; establishes county health department procedures regarding review of nurse registries comprehensive emergency plans, provides for notification of plan approval or deficiency; and provides that the Agency for Health Care Administration may impose a fine under certain circumstances.

Section 9. Amends s. 400.610, F.S, regarding hospice facilities and the provision of services during an emergency; provides that hospice facilities may establish links to local emergency operations centers; establishes county health department procedures regarding the review of hospice facilities comprehensive emergency plans; provides for notification of plan approval or deficiency; and provides sanctioning ability by Agency for Health Care Administration.

Section 10. Amends s. 400.925, F.S., providing the definition of life-supporting or life-sustaining equipment.

Section 11. Amends s. 400.934, F.S., regarding home medical equipment providers and the provision of services during an emergency; provides that home medical equipments providers may establish links to local emergency operations centers; establishes county health department procedures regarding review of home medical equipment providers comprehensive emergency plans; provides for notification of plan approval or deficiency; and provides that the Agency for Health Care Administration may impose a fine under certain circumstances.

Section 12. Amends s. 400.935, F.S., providing rules establishing minimum standards.

Section 13. Amends s. 408.831, F.S., regarding facility licensure and the provision of certain licensure and facility use pre and post disaster.

Section 14. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

The Department of Health estimates that the increase in the coordination and number of comprehensive emergency management plan reviews would require the following budget:

	2006-07	2007-08
Salaries		
28 FTE SpNS Spec. @ $55,000 (paygrade 026) (1st Year 4 FTE start July 1 = $211,200; 24 FTE w/ 50% lapse = $633,600)	844,800	1,971,200
2 Admin. Asst. III @ $40,000 (paygrade 418) (w/ 28% benefits + 25% lapse)	76,800	102,400
OPS	11,790	11,790
Expense		
30 FTE @ standard DOH professional	393,510	393,510
w/ medium travel @$16,460	100,290	
OCO		
30 FTE @ standard DOH professional $1,900	57,000	
Recurring	1,326,900	2,478,900
Nonrecurring	157,290	
General Revenue Fund Total	1,484,190	2,478,900

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None

D. FISCAL COMMENTS:

The Department of Health estimates the additional responsibilities associated with the increase in comprehensive emergency management plan reviews to require $2.7M in initial funding. The Department of Community Affairs, the Department of Elder Affairs, and the Agency for Health Care Administration, should be able to carry out the provision of the bill within existing resources. Certain provisions of the bill are conditional upon funding.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Counties are already involved in emergency management activities, and the bill does not appear to impose significant new responsibilities upon them. The fiscal impact, if any, on counties is nonexistent or insignificant. The bill does not appear to require a municipality to expend funds or to take actions requiring the expenditure of funds.

2. Other:

None

B. RULE-MAKING AUTHORITY:

The Department of Health is required to promulgate rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On February 22, 2006, the House Health Care General Committee passed Proposed Committee Bill HCG 06-01 and adopted two amendments:

Amendment #1: A strike-all amendment which included the provisions contained within the PCB and the following revisions:

- Increase special needs registration notification requirements;
- Require the Division of Emergency Management to address evacuation of persons with pets in the shelter component of the state emergency management plan;

- Require the Department of Agriculture and Consumer Services to assist the division of Emergency Management in determining strategies regarding persons evacuating with pets;
- Require the Division of Emergency Management to inspect facilities to determine availability, readiness and adequacy of facilities;
- Assign responsibility for the designation, operation and infrastructure of special needs shelters requires local health departments to coordinate efforts regarding same;
- Add the Florida Renal Coalition to the membership of the Special Needs Interagency Committee;
- Increase coordination among entities regarding home health agency, nurse registry, hospice and home medical equipment comprehensive plan reviews by local health departments.

Amendment #2:

- Provide access to special needs registration information to local law enforcement agencies.

The analysis reflects the bill as amended.

A bill to be entitled

An act relating to emergency management; amending s. 252.355, F.S.; specifying additional entities and agencies that are required to provide registration information to persons with disabilities or special needs for purposes of inclusion within the registry of persons with special needs maintained by local emergency management agencies; providing that the Department of Community Affairs shall be the designated lead agency responsible for community education and outreach to the general public, including persons with special needs, regarding registration as a person with special needs, special needs shelters, and general information regarding shelter stays; requiring the department to disseminate educational and outreach information through local emergency management offices; requiring the department to coordinate community education and outreach related to special needs shelters with specified agencies and entities; providing that special needs shelters must allow persons with special needs to bring service animals into special needs shelters; revising provisions with respect to the required notification of residential utility customers of the availability of the special needs registration program; providing that specified confidential and exempt information relating to registration of persons with special needs be provided to the Department of Health and local law enforcement agencies; creating s. 252.3568, F.S.; requiring the Division of Emergency Management to

address evacuation of persons with pets in the shelter component of the state comprehensive emergency management plan; creating s. 252.357, F.S., requiring the Florida Comprehensive Emergency Management Plan to permit the Agency for Health Care Administration to make initial contact with each nursing home in a disaster area; requiring the agency to annually publish an emergency telephone number that may be used by nursing homes to contact the agency; amending s. 252.385, F.S., relating to public shelter space; requiring the Division of Emergency Management of the Department of Community Affairs to biennially prepare and submit a statewide emergency shelter plan to the Governor and the Cabinet for approval; providing plan requirements; requiring the Department of Health to provide specified assistance to the division; revising those facilities which are excluded as being suitable for use as public hurricane evacuation shelters; requiring local emergency management agencies to inspect a designated facility prior to activation to determine its readiness; amending s. 381.0303, F.S.; providing for the operation, maintenance, and closure of special needs shelters; providing that local Children's Medical Services offices shall assume lead responsibility for specified coordination with respect to the development of a plan for the staffing and medical management of pediatric special needs shelters; requiring such plans to conform to the local comprehensive emergency management plan; requiring county governments to assist the Department of Health with

nonmedical staffing and operation of special needs shelters; requiring local health departments and emergency management agencies to coordinate such efforts to ensure appropriate staffing; providing that the appropriate county health department, Children's Medical Services office, and local emergency management agency shall jointly determine the responsibility for medical supervision in a special needs shelter; providing notification requirements; requiring local emergency management agencies to be responsible for the infrastructure and closure of special needs shelters; requiring the emergency management agency and the local health department to coordinate efforts to ensure appropriate designation, operation, and infrastructure in special needs shelters; providing that a county health department is not prohibited from entering into an alternative agreement with a local emergency management agency to assume the lead responsibility for special needs shelter supplies and equipment; providing that state employees with a preestablished role in disaster response are subject to serve in times of disaster in specified capacities; requiring the Secretary of Elderly Affairs to convene multiagency special needs shelter discharge planning teams to assist local areas that are severely impacted by a natural or manmade disaster that requires the use of special needs shelters; providing duties and responsibilities of such discharge planning teams; providing for the inclusion of specified state agency

representatives on each discharge planning team; revising provisions relating to reimbursement of health care practitioners; providing for eligibility of specified health care facilities for reimbursement when a multiagency special needs shelter discharge planning team discharges persons with special needs to such receiving facilities; providing procedures and requirements with respect to such reimbursement; requiring the department to specify by rule expenses that are reimbursable and the rate of reimbursement for services; revising provisions which prescribe means of and procedures for reimbursement; disallowing specified reimbursements; revising provisions with respect to the organization, role, duties, and composition of the special needs shelter interagency committee; requiring the department to adopt specified rules with respect to special needs shelters; providing requirements with respect to emergency management plans submitted to a county health department by a home health agency, nurse registry, hospice, or home medical equipment provider; amending ss. 400.492, 400.497, 400.506, 400.610, and 400.934, F.S.; revising requirements with respect to the comprehensive emergency management plans of home health agencies, nurse registries, and hospices, and providing such requirements with respect to home medical equipment providers, to include the means by which continuing services will be provided to patients who evacuate to special needs shelters; authorizing the establishment of links to local emergency operations

centers for specified purposes; providing actions that constitute abandonment of a patient; providing sanctions for abandonment; revising requirements of a county health department with respect to review of a comprehensive emergency management plan submitted by a home health agency, nurse registry, or hospice, and providing such requirements with respect to a home medical equipment provider; providing requirements upon failure to submit a plan or requested information to the department; providing for imposition of a fine; revising requirements of the Department of Health with respect to review of the plan of a home health agency, nurse registry, or hospice that operates in more than one county, and providing such requirements with respect to a home medical equipment provider that operates in more than one county; providing that the preparation and maintenance of a comprehensive emergency management plan by a home medical equipment provider is a requirement for licensure and must meet minimum criteria established by the Agency for Health Care Administration; providing plan requirements; providing that the plan is subject to review and approval by the county health department; requiring each home medical equipment provider to maintain a current prioritized list of patients who need continued services during an emergency; amending s. 400.925, F.S.; defining "life-supporting or life-sustaining equipment" for purposes of pt. X of ch. 400, F.S., relating to home medical equipment providers; amending s. 400.935, F.S.; requiring the Agency

for Health Care Administration to adopt rules with respect to the comprehensive emergency management plan prepared by a home medical equipment services provider; amending s. 408.831, F.S.; providing that entities regulated or licensed by the Agency for Health Care Administration may exceed their licensed capacity to act as a receiving facility under specified circumstances; providing requirements while such entities are in an overcapacity status; providing for issuance of an inactive license to such licensees under specified conditions; providing requirements and procedures with respect to the issuance and reactivation of an inactive license; providing fees; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 252.355, Florida Statutes, is amended to read:

252.355 Registry of persons with special needs; notice.--

(1) In order to meet the special needs of persons who would need assistance during evacuations and sheltering because of physical, mental, <u>cognitive impairment,</u> or sensory disabilities, each local emergency management agency in the state shall maintain a registry of persons with special needs located within the jurisdiction of the local agency. The registration shall identify those persons in need of assistance and plan for resource allocation to meet those identified needs. To assist the local emergency management agency in identifying

such persons, home health agencies, hospices, nurse registries, home medical equipment providers, the Department of Children and Family Services, the Department of Health, the Agency for Health Care Administration, the Department of Education, Agency for Persons with Disabilities, ~~Department of Labor and Employment Security,~~ and the Department of Elderly Affairs shall provide registration information to all of their special needs clients and to all people with disabilities or special needs who receive services ~~incoming clients as a part of the intake process~~. The registry shall be continuously maintained ~~updated annually~~. The registration program shall give persons with special needs the option of preauthorizing emergency response personnel to enter their homes during search and rescue operations if necessary to assure their safety and welfare following disasters.

(2) The Department of Community Affairs shall be the designated lead agency responsible for community education and outreach to the general public, including special needs clients, regarding registration and special needs shelters and general information regarding shelter stays. The Department of Community Affairs shall disseminate such educational and outreach information through the local emergency management offices. The department shall coordinate the development of curriculum and dissemination of all community education and outreach related to special needs shelters with the Clearinghouse on Disability Information of the Governor's Working Group on the Americans with Disabilities Act, the Department of Children and Family Services, the Department of Health, the Agency for Health Care Administration, the Department of Education, the Agency for

Persons with Disabilities, and the Department of Elderly Affairs.

(3) A person with special needs shall be allowed to bring his or her service animal into a special needs shelter in compliance with the Americans with Disabilities Act of 1990, Pub. L. No. 101-336. Because a special needs shelter is considered a public facility when it is activated for a disaster, persons with disabilities must be allowed access to special needs shelters when accompanied by a service animal in compliance with the Americans with Disabilities Act, which provides that businesses and organizations that serve the public must allow people with disabilities to bring their service animals into all areas of a facility where customers are normally allowed to go.

(4) ~~(2) On or before May 1 of each year~~ Each electric utility in the state shall ~~annually~~ notify residential customers in its service area of the availability of the registration program available through their local emergency management agency with either: ~~:~~

(a) An initial notification upon the activation of new residential service with the electric utility followed by one annual notification between January 1 and May 31; or

(b) Two separate annual notifications between January 1 and May 31.

The notification required under this subsection may be made by any available means, including, but not limited to, written, electronic, or verbal notification, and may be made concurrently

with any other notification to residential customers required by law or rule.

(5) ~~(3)~~ All records, data, information, correspondence, and communications relating to the registration of persons with special needs as provided in subsection (1) are confidential and exempt from the provisions of s. 119.07(1), except that such information shall be available to other emergency response agencies, as determined by the local emergency management director, and to the Department of Health in the furtherance of its duties and responsibilities. Local law enforcement agencies shall be provided complete shelter registration information upon request.

(6) ~~(4)~~ All appropriate agencies and community-based service providers, including home health care providers, hospices, nurse registries, and home medical equipment providers, shall assist emergency management agencies by collecting registration information for persons with special needs as part of program intake processes, establishing programs to increase the awareness of the registration process, and educating clients about the procedures that may be necessary for their safety during disasters. Clients of state or federally funded service programs with physical, mental, cognitive impairment, or sensory disabilities who need assistance in evacuating, or when in shelters, must register as persons with special needs.

Section 2. Section 252.3568, Florida Statutes, is created to read:

252.3568 Emergency sheltering of persons with pets.--In

accordance with the provisions of s. 252.35, the division shall address the evacuation of persons with pets in the shelter component of the state comprehensive emergency management plan. The Department of Agriculture and Consumer Services shall assist the division in determining strategies regarding this activity.

Section 3. Section 252.357, Florida Statutes, is created to read:

252.357 Monitoring of nursing homes during disaster.--The Florida Comprehensive Emergency Management Plan shall permit the Agency for Health Care Administration, working from the agency's offices or in the Emergency Operations Center, ESF-8, to make initial contact with each nursing home in the disaster area. The agency, by July 15, 2006, and annually thereafter, shall publish on the Internet an emergency telephone number that may be used by nursing homes to contact the agency on a schedule established by the agency to report requests for assistance. The agency may also provide the telephone number to each facility when it makes the initial facility call.

Section 4. Subsection (2) and paragraphs (a) and (b) of subsection (4) of section 252.385, Florida Statutes, are amended to read:

252.385 Public shelter space.--

(2)(a) The division shall administer a program to survey existing schools, universities, community colleges, and other state-owned, municipally owned, and county-owned public buildings and any private facility that the owner, in writing, agrees to provide for use as a public hurricane evacuation shelter to identify those that are appropriately designed and

located to serve as such shelters. The owners of the facilities must be given the opportunity to participate in the surveys. The Board of Regents, district school boards, community college boards of trustees, and the Department of Education are responsible for coordinating and implementing the survey of public schools, universities, and community colleges with the division or the local emergency management agency.

(b) By January 31 of each even-numbered year, the division shall prepare and submit a statewide emergency shelter plan to the Governor and the Cabinet for approval, subject to the requirements for approval provided in s. 1013.37(2). The plan shall identify the general location and square footage of special needs shelters, by regional planning council region, during the next 5 years. The plan shall also include information on the availability of shelters that accept pets. The Department of Health shall assist the division in determining the estimated need for special needs shelter space and the adequacy of facilities to meet the needs of persons with special needs based on information from the registries of persons with special needs and other information.

(4)(a) Public facilities, including schools, postsecondary education facilities, and other facilities owned or leased by the state or local governments, but excluding hospitals, hospice care facilities, assisted living facilities, or nursing homes, which are suitable for use as public hurricane evacuation shelters shall be made available at the request of the local emergency management agencies. The local emergency management agency shall inspect a designated facility to determine its

readiness prior to activating the facility for a specific hurricane or disaster. Such agencies shall coordinate with the appropriate school board, university, community college, or local governing board when requesting the use of such facilities as public hurricane evacuation shelters.

(b) The Department of Management Services shall incorporate provisions for the use of suitable leased public facilities as public hurricane evacuation shelters into lease agreements for state agencies. Suitable leased public facilities include leased public facilities that are solely occupied by state agencies and have at least 2,000 square feet of net floor area in a single room or in a combination of rooms having a minimum of 400 square feet in each room. The net square footage of floor area shall ~~must~~ be determined by subtracting from the gross square footage the square footage of spaces such as mechanical and electrical rooms, storage rooms, open corridors, restrooms, kitchens, science or computer laboratories, shop or mechanical areas, administrative offices, records vaults, and crawl spaces.

Section 5. Section 381.0303, Florida Statutes, is amended to read:

381.0303 ~~Health practitioner recruitment for~~ Special needs shelters.--

(1) PURPOSE.--The purpose of this section is to provide for the operation, maintenance, and closure of special needs shelters and to designate the Department of Health, through its county health departments, as the lead agency for coordination of the recruitment of health care practitioners, as defined in

s. 456.001(4), to staff special needs shelters in times of emergency or disaster and to provide resources to the department to carry out this responsibility. However, nothing in this section prohibits a county health department from entering into an agreement with a local emergency management agency to assume the lead responsibility for recruiting health care practitioners.

(2) SPECIAL NEEDS SHELTER PLAN; STAFFING; CLOSURE; STATE AGENCY ASSISTANCE ~~AND STAFFING~~.--Provided funds have been appropriated to support ~~medical services~~ disaster coordinator positions in county health departments:~~,~~

(a) The department shall assume lead responsibility for the ~~local~~ coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of special needs shelters. The local Children's Medical Services offices shall assume lead responsibility for the coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of pediatric special needs shelters. Plans shall conform to ~~The plan shall be in conformance with~~ the local comprehensive emergency management plan.

(b)~~(a)~~ County health departments shall, in conjunction with the local emergency management agencies, have the lead responsibility for coordination of the recruitment of health care practitioners to staff local special needs shelters. County health departments shall assign their employees to work in

special needs shelters when those employees are needed to protect the health and safety of persons with special needs ~~of patients~~. County governments shall assist the Department of Health with nonmedical staffing and the operation of special needs shelters. The local health department and emergency management agency shall coordinate these efforts to ensure appropriate staffing in special needs shelters.

(c) ~~(b)~~ The appropriate county health department, Children's Medical Services office, and local emergency management agency shall jointly decide ~~determine~~ who has responsibility for medical supervision in each ~~a~~ special needs shelter and shall notify the Division of Emergency Management and the Department of Health of their decision.

(d) ~~(c)~~ Local emergency management agencies shall be responsible for the designation, ~~and~~ operation, and infrastructure of special needs shelters during times of emergency or disaster and the closure of the facilities following an emergency or disaster. The emergency management agency and the local health department shall coordinate these efforts to ensure appropriate designation, operation, and infrastructure in special needs shelters. County health departments shall assist the local emergency management agency with regard to the management of medical services in special needs shelters. However, nothing in this section prohibits a county health department from entering into an alternative agreement with a local emergency management agency to assume the lead responsibility for special needs shelter supplies and equipment.

(e) Any state employee with a preestablished role in disaster response that has been designated by the employing agency is subject to serve in times of disaster in a capacity that is commensurate with the employee's knowledge, skills, and abilities and to participate in any needed activities related to the disaster unless the employee has other mandated response activities that preclude participation.

(f) The Secretary of Elderly Affairs, or his or her designee, shall convene, at any time that he or she deems appropriate and necessary, a multiagency special needs shelter discharge planning team or teams to assist local areas that are severely impacted by a natural or manmade disaster that requires the use of special needs shelters. Multiagency special needs shelter discharge planning teams shall provide assistance to local emergency management agencies with the continued operation or closure of the shelters, as well as with the discharge of special needs clients to alternate facilities if necessary. Local emergency management agencies may request the assistance of a multiagency special needs shelter discharge planning team by alerting statewide emergency management officials of the necessity for additional assistance in their area. The Secretary of Elderly Affairs is encouraged to proactively work with other state agencies prior to any natural disasters for which warnings are provided to ensure that multiagency special needs shelter discharge planning teams are ready to assemble and deploy rapidly upon a determination by state emergency management officials that a disaster area requires additional assistance. The Secretary of Elderly Affairs may call upon any state agency

or office to provide staff to assist a multiagency special needs shelter discharge planning team or teams. Unless the secretary determines that the nature or circumstances surrounding the disaster do not warrant participation from a particular agency's staff, each multiagency special needs shelter discharge planning team shall include at least one representative from each of the following state agencies:

1. Department of Elderly Affairs.

2. Department of Health.

3. Department of Children and Family Services.

4. Department of Veterans' Affairs.

5. Department of Community Affairs.

6. Agency for Health Care Administration.

7. Agency for Persons with Disabilities.

(3) REIMBURSEMENT TO HEALTH CARE PRACTITIONERS AND FACILITIES.--

(a) The Department of Health shall upon request reimburse~~, subject to the availability of funds for this purpose,~~ health care practitioners, as defined in s. 456.001, provided the practitioner is not providing care to a patient under an existing contract, and emergency medical technicians and paramedics licensed under ~~pursuant to~~ chapter 401 for medical care provided at the request of the department in special needs shelters or at other locations during times of emergency or a declared ~~major~~ disaster. Reimbursement for health care practitioners, except for physicians licensed under ~~pursuant to~~ chapter 458 or chapter 459, shall be based on the average hourly rate that such practitioners were paid according to the most

recent survey of Florida hospitals conducted by the Florida Hospital Association or other nationally or state recognized data source. Reimbursement shall be requested on forms prepared by the Department of Health and shall be paid as specified in paragraph (c).

(b) If, upon closure of a special needs shelter, a multiagency special needs shelter discharge planning team determines that it is necessary to discharge persons with special needs to other health care facilities, such as hospitals, nursing homes, assisted living facilities, and community residential homes, the receiving facilities shall be eligible for reimbursement for services provided to the individuals for up to 90 days. Any facility eligible for reimbursement under this paragraph shall submit invoices for reimbursement on forms developed by the department. A facility must show proof of a written request from a representative of an agency serving on the multiagency special needs shelter discharge planning team that the individual for whom the facility is seeking reimbursement for services rendered was referred to that facility from a special needs shelter. The department shall specify by rule which expenses are reimbursable and the rate of reimbursement for each service. Reimbursement for the services described in this paragraph shall be paid as specified in paragraph (c).

(c) If a Presidential Disaster Declaration has been issued ~~made, and the Federal Government makes funds available~~, the department shall request federal ~~use such funds for~~ reimbursement of eligible expenditures. In other situations, or

if federal funds do not fully compensate the department for reimbursements permissible under ~~reimbursement made pursuant to~~ this section, the department shall process a budget amendment to obtain reimbursement from unobligated, unappropriated moneys in the General Revenue Fund. The department shall not provide reimbursement to facilities under this subsection for services provided to a person with special needs if, during the period of time in which the services were provided, the individual was enrolled in another state-funded program, such as Medicaid or another similar program, was covered under a policy of health insurance as defined in s. 624.603, or was a member of a health maintenance organization or prepaid health clinic as defined in chapter 641, which would otherwise pay for the same services. Travel expense and per diem costs shall be reimbursed pursuant to s. 112.061.

(4) HEALTH CARE PRACTITIONER REGISTRY.--The department may use the registries established in ss. 401.273 and 456.38 when health care practitioners are needed to staff special needs shelters or to assist with other disaster-related activities ~~staff disaster medical assistance teams~~.

(5) SPECIAL NEEDS SHELTER INTERAGENCY COMMITTEE.--The Secretary ~~Department~~ of Health may establish a special needs shelter interagency committee and serve as or appoint a designee to serve as the committee's chair. The department shall provide any necessary staff and resources to support the committee in the performance of its duties~~, to be chaired and staffed by the department~~. The committee shall address and resolve problems related to special needs shelters not addressed in the state

comprehensive emergency medical plan and shall consult on ~~serve as an oversight committee to monitor~~ the planning and operation of special needs shelters.

(a) The committee shall ~~may~~:

1. Develop, ~~and~~ negotiate, and regularly review any necessary interagency agreements.

2. Undertake other such activities as the department deems necessary to facilitate the implementation of this section.

3. Submit recommendations to the Legislature as necessary.

(b) The special needs shelter interagency committee shall be composed of representatives of emergency management, health, medical, and social services organizations. Membership shall include, but shall not be limited to, representatives of the Departments of Health, Community Affairs, Children and Family Services, Elderly Affairs, ~~Labor and Employment Security,~~ and Education; the Agency for Health Care Administration; the Florida Medical Association; the Florida Osteopathic Medical Association; Associated Home Health Industries of Florida, Inc.; the Florida Nurses Association; the Florida Health Care Association; the Florida Assisted Living Affiliation ~~Association~~; the Florida Hospital Association; the Florida Statutory Teaching Hospital Council; the Florida Association of Homes for the Aging; the Florida Emergency Preparedness Association; the American Red Cross; Florida Hospices and Palliative Care, Inc.; the Association of Community Hospitals and Health Systems; the Florida Association of Health Maintenance Organizations; the Florida League of Health Systems; Private Care Association; ~~and~~ the Salvation Army; the Florida

Association of Aging Services Providers; AARP; and the Florida Renal Coalition.

(c) Meetings of the committee shall be held in Tallahassee, and members of the committee shall serve at the expense of the agencies or organizations they represent. The committee shall make every effort to use teleconference or video conference capabilities in order to ensure statewide input and participation.

(6) RULES.--The department has the authority to adopt rules necessary to implement this section. Rules shall ~~may~~ include:

(a) The ~~a~~ definition of a "person with special needs", including eligibility criteria for individuals with physical, mental, cognitive impairment, or sensory disabilities and the services a person with special needs can expect to receive in a special needs shelter ~~patient, specify physician reimbursement, and designate which county health departments will have responsibility for implementation of subsections (2) and (3)~~.

(b) The process for special needs shelter health care practitioners and facility reimbursement for services provided in a disaster.

(c) Guidelines for special needs shelter staffing levels to provide services.

(d) The definition of and standards for special needs shelter supplies and equipment, including durable medical equipment.

(e) Compliance with applicable laws relating to service animals.

(f) Standards for the special needs shelter registration

process, including guidelines for addressing the needs of unregistered persons in need of a special needs shelter.

(g) Standards for addressing the needs of families where only one dependent is eligible for admission to a special needs shelter and the needs of adults with special needs who are caregivers for individuals without special needs.

(h) The requirement of the county health departments to seek the participation of hospitals, nursing homes, assisted living facilities, home health agencies, hospice providers, nurse registries, home medical equipment providers, dialysis centers, and other health and medical emergency preparedness stakeholders in preevent planning activities.

(7) ~~REVIEW OF~~ EMERGENCY MANAGEMENT PLANS; CONTINUITY OF CARE.--Each emergency management plan submitted to a county health department by a home health agency under s. 400.492, by a nurse registry pursuant to s. 400.506(16)(e), by a hospice pursuant to s. 400.610(1)(b), or by a home medical equipment provider pursuant to s. 400.934(20)(a) shall specify the means by which the home health agency, nurse registry, hospice, or home medical equipment provider will continue to provide staff and equipment to perform the same type and quantity of services for their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The submission of emergency management plans to county health departments by home health agencies, ~~pursuant to s. 400.497(8)(c) and (d) and by~~ nurse registries, ~~pursuant to s. 400.506(16)(e) and by~~ hospice programs, ~~pursuant to s. 400.610(1)(b)~~ and home medical equipment providers is

conditional upon the receipt of an appropriation by the department to establish ~~medical services~~ disaster coordinator positions in county health departments unless the secretary of the department and a local county commission jointly determine to require such plans to be submitted based on a determination that there is a special need to protect public health in the local area during an emergency.

Section 6. Section 400.492, Florida Statutes, is amended to read:

400.492 Provision of services during an emergency.--Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national or state accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The plan shall describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other organizations

subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do

not go to the location specified in their patient records. Home health agencies may establish links to local emergency operations centers to determine a mechanism to approach specific areas within a disaster area in order for the agency to reach its clients. The presentation of a home health agency client to a special needs shelter without the home health agency making a good faith effort to provide services in the shelter setting shall be considered abandonment of the client and constitutes a class II deficiency, subject to sanctions provided in s. 400.484(2)(b). For purposes of this section, "good faith effort" may be demonstrated by documented attempts of staff to follow procedures as outlined in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that continuing care has been provided for those patients who have been identified as needing care by the home health agency in the event of an emergency or disaster under subsection (1).

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

Section 7. Paragraphs (c) and (d) of subsection (8) of section 400.497, Florida Statutes, are amended to read:

400.497 Rules establishing minimum standards.--The agency shall adopt, publish, and enforce rules to implement this part, including, as applicable, ss. 400.506 and 400.509, which must provide reasonable and fair minimum standards relating to:

(8) Preparation of a comprehensive emergency management

plan pursuant to s. 400.492.

(c) The plan is subject to review and approval by the county health department. During its review, the county health department shall contact state and local health and medical stakeholders during its review when necessary. ~~ensure that the following agencies, at a minimum, are given the opportunity to review the plan:~~

~~1. The local emergency management agency.~~

~~2. The Agency for Health Care Administration.~~

~~3. The local chapter of the American Red Cross or other lead sheltering agency.~~

~~4. The district office of the Department of Children and Family Services.~~

The county health department shall complete its review to ensure that the plan is in accordance with the criteria set forth in the rules of the Agency for Health Care Administration within 90 ~~60~~ days after receipt of the plan and shall either approve the plan or advise the home health agency of necessary revisions. If the home health agency fails to submit a plan or fails to submit the requested information or revisions to the county health department within 30 days after written notification from the county health department, the county health department shall notify the Agency for Health Care Administration. The agency shall notify the home health agency that such failure constitutes a deficiency, subject to a fine of $5,000 per occurrence. If the plan is not submitted, information is not provided, or revisions are not made as requested, the agency may

impose the fine.

(d) For any home health agency that operates in more than one county, the Department of Health shall review the plan, after consulting with state and local health and medical stakeholders, when necessary ~~all of the county health departments, the agency, and all the local chapters of the American Red Cross or other lead sheltering agencies in the areas of operation for that particular home health agency~~. The department ~~of Health~~ shall complete its review within 90 days after receipt of the plan and shall either approve the plan or advise the home health agency of necessary revisions. The department ~~of Health~~ shall make every effort to avoid imposing differing requirements on a home health agency that operates in more than one county as a result of differing or conflicting comprehensive plan requirements of the ~~based on differences between~~ counties in which ~~on~~ the home health agency operates.

Section 8. Subsection (16) of section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.--

(16) Each nurse registry shall prepare and maintain a comprehensive emergency management plan that is consistent with the criteria in this subsection and with the local special needs plan. The plan shall be updated annually. The plan shall include the means by which the nurse registry will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The plan shall

specify how the nurse registry shall facilitate the provision of continuous care by persons referred for contract to persons who are registered pursuant to s. 252.355 during an emergency that interrupts the provision of care or services in private residencies. Nurse registries may establish links to local emergency operations centers to determine a mechanism to approach specific areas within a disaster area in order for a provider to reach its clients. The presentation of nurse registry clients to a special needs shelter without the nurse registry provider making a good faith effort to provide services in the shelter setting shall be considered abandonment of the patient and constitutes a class II deficiency, subject to sanctions provided in s. 400.484(2)(b). For purposes of this section, "good faith effort" may be demonstrated by documented attempts of staff to follow procedures as outlined in the nurse registry's comprehensive emergency management plan which support a finding that continuing care has been provided for those patients who have been identified as needing care by the nurse registry in the event of an emergency under s. 400.506(1).

(a) All persons referred for contract who care for persons registered pursuant to s. 252.355 must include in the patient record a description of how care will be continued during a disaster or emergency that interrupts the provision of care in the patient's home. It shall be the responsibility of the person referred for contract to ensure that continuous care is provided.

(b) Each nurse registry shall maintain a current prioritized list of patients in private residences who are

registered pursuant to s. 252.355 and are under the care of persons referred for contract and who need continued services during an emergency. This list shall indicate, for each patient, if the client is to be transported to a special needs shelter and if the patient is receiving skilled nursing services. Nurse registries shall make this list available to county health departments and to local emergency management agencies upon request.

(c) Each person referred for contract who is caring for a patient who is registered pursuant to s. 252.355 shall provide a list of the patient's medication and equipment needs to the nurse registry. Each person referred for contract shall make this information available to county health departments and to local emergency management agencies upon request.

(d) Each person referred for contract shall not be required to continue to provide care to patients in emergency situations that are beyond the person's control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records.

(e) The comprehensive emergency management plan required by this subsection is subject to review and approval by the county health department. During its review, the county health department shall <u>contact state and local health and medical stakeholders, when necessary</u> ~~ensure that, at a minimum, the local emergency management agency, the Agency for Health Care Administration, and the local chapter of the American Red Cross or other lead sheltering agency are given the opportunity to~~

~~review the plan~~. The county health department shall complete its review to ensure that the plan is in accordance with the criteria set forth in the rules of the Agency for Health Care Administration within 90 ~~60~~ days after receipt of the plan and shall either approve the plan or advise the nurse registry of necessary revisions. If a nurse registry fails to submit a plan or fails to submit requested information or revisions to the county health department within 30 days after written notification from the county health department, the county health department shall notify the Agency for Health Care Administration. The agency shall notify the nurse registry that such failure constitutes a deficiency, subject to a fine of $5,000 per occurrence. If the plan is not submitted, information is not provided, or revisions are not made as requested, the agency may impose the fine.

(f) The Department of Health shall review the comprehensive emergency management plan of any nurse registry that operates in more than one county. The department shall complete its review within 90 days after receipt of the plan and shall either approve the plan or advise the nurse registry of necessary revisions. The department shall make every effort to avoid imposing differing requirements on nurse registries that operate in more than one county as a result of differing or conflicting comprehensive plan requirements of the counties in which the nurse registry operates.

(g) ~~(f)~~ The Agency for Health Care Administration shall adopt rules establishing minimum criteria for the comprehensive emergency management plan and plan updates required by this

subsection, with the concurrence of the Department of Health and in consultation with the Department of Community Affairs.

Section 9. Paragraph (b) of subsection (1) of section 400.610, Florida Statutes, is amended to read:

400.610 Administration and management of a hospice.--

(1) A hospice shall have a clearly defined organized governing body, consisting of a minimum of seven persons who are representative of the general population of the community served. The governing body shall have autonomous authority and responsibility for the operation of the hospice and shall meet at least quarterly. The governing body shall:

(b)1. Prepare and maintain a comprehensive emergency management plan that provides for continuing hospice services in the event of an emergency that is consistent with local special needs plans. The plan shall include provisions for ensuring continuing care to hospice patients who go to special needs shelters. The plan shall include the means by which the hospice provider will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The plan is subject to review and approval by the county health department, except as provided in subparagraph 2. During its review, the county health department shall contact state and local health and medical stakeholders, when necessary ~~ensure that the department, the agency, and the local chapter of the American Red Cross or other lead sheltering agency have an opportunity to review and comment on the plan~~. The county health department shall complete its review to ensure

that the plan is in accordance with the criteria set forth in the rules of the Department of Elderly Affairs within 90 ~~60~~ days after receipt of the plan and shall either approve the plan or advise the hospice of necessary revisions. Hospice providers may establish links to local emergency operations centers to determine a mechanism to approach specific areas within a disaster area in order for the provider to reach its clients. The presentation of hospice clients to a special needs shelter without the hospice provider making a good faith effort to provide services in the shelter setting shall be considered abandonment of the client subject to sanction as provided by law or rule. For the purposes of this section, "good faith effort" may be demonstrated by documented attempts of staff to follow procedures as outlined in the hospice's comprehensive emergency management plan and to provide continuing care for those hospice clients who have been identified as needing alternative caregiver services in the event of an emergency.

2. For any hospice that operates in more than one county, the Department of Health during its review shall contact state and local health and medical stakeholders, when necessary ~~review the plan, after consulting with all of the county health departments, the agency, and all the local chapters of the American Red Cross or other lead sheltering agency in the areas of operation for that particular hospice~~. The Department of Health shall complete its review to ensure that the plan is in accordance with the criteria set forth in the rules of the Department of Elderly Affairs within 90 days after receipt of the plan and shall either approve the plan or advise the hospice

of necessary revisions. The Department of Health shall make every effort to avoid imposing ~~on the hospice~~ differing requirements on a hospice that operates in more than one county as a result of differing or conflicting comprehensive plan requirements of the ~~based on differences between~~ counties in which the hospice operates.

Section 10. Subsections (13) through (16) of section 400.925, Florida Statutes, are renumbered as subsections (14) through (17), respectively, and a new subsection (13) is added to that section to read:

400.925 Definitions.--As used in this part, the term:

(13) "Life-supporting or life-sustaining equipment" means a device that is essential to, or that yields information that is essential to, the restoration or continuation of a bodily function important to the continuation of human life. Life-supporting or life-sustaining equipment includes apnea monitors, enteral feeding pumps, infusion pumps, portable home dialysis equipment, and ventilator equipment and supplies for all related equipment, including oxygen equipment and related respiratory equipment.

Section 11. Subsections (20), (21), and (22) are added to section 400.934, Florida Statutes, to read:

400.934 Minimum standards.--As a requirement of licensure, home medical equipment providers shall:

(20)(a) Prepare and maintain a comprehensive emergency management plan that meets minimum criteria established by the agency in rule under s. 400.935. The plan shall be updated annually and shall provide for continuing home medical equipment

services for life-supporting or life-sustaining equipment, as defined in 400.925, during an emergency that interrupts home medical equipment services in a patient's home. The plan shall include:

1. The means by which the home medical equipment provider will continue to provide equipment to perform the same type and quantity of services to its patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation.

2. The means by which the home medical equipment provider establishes and maintains an effective response to emergencies and disasters, including plans for:

a. Notification of staff when emergency response measures are initiated.

b. Communication between staff members, county health departments, and local emergency management agencies, which shall include provisions for a backup communications system.

c. Identification of resources necessary to continue essential care or services or referrals to other organizations subject to written agreement.

d. Contacting and prioritizing patients in need of continued medical equipment services and supplies.

(b) The plan is subject to review and approval by the county health department. During its review, the county health department shall contact state and local health and medical stakeholders, when necessary. The county health department shall complete its review to ensure that the plan is in accordance with the criteria set forth in the rules of the Agency for

Health Care Administration within 90 days after receipt of the plan. If a home medical equipment provider fails to submit a plan or fails to submit requested information or revisions to the county health department within 30 days after written notification from the county health department, the county health department shall notify the Agency for Health Care Administration. The agency shall notify the home medical equipment provider that such failure constitutes a deficiency, subject to a fine of $5,000 per occurrence. If the plan is not submitted, information is not provided, or revisions are not made as requested, the agency may impose the fine.

(c) The Department of Health shall review the comprehensive emergency management plan of any home medical equipment provider that operates in more than one county. The department shall complete its review within 90 days after receipt of the plan and shall either approve the plan or advise the home medical equipment provider of necessary revisions. The department shall make every effort to avoid imposing differing requirements on home medical equipment providers that operate in more than one county as a result of differing or conflicting comprehensive plan requirements of the counties in which the home medical equipment provider operates.

(21) Each home medical equipment provider shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate the means by which services shall be continued for each patient in the event of an emergency or disaster, whether the patient is to be transported to a special needs shelter, and whether the patient has life-

supporting or life-sustaining equipment, including the specific type of equipment and related supplies. The list shall be furnished to county health departments and local emergency management agencies, upon request.

(22) Home medical equipment providers may establish links to local emergency operations centers to determine a mechanism to approach specific areas within a disaster area in order for the provider to reach its patients.

Section 12. Subsection (11) is added to section 400.935, Florida Statutes, to read:

400.935 Rules establishing minimum standards.--The agency shall adopt, publish, and enforce rules to implement this part, which must provide reasonable and fair minimum standards relating to:

(11) Preparation of the comprehensive emergency management plan under s. 400.934 and the establishment of minimum criteria for the plan, including the maintenance of patient equipment and supply lists that can accompany patients who are transported from their homes. Such rules shall be formulated in consultation with the Department of Health and the Department of Community Affairs.

Section 13. Section 408.831, Florida Statutes, is amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.--

(1) In addition to any other remedies provided by law, the agency may deny each application or suspend or revoke each license, registration, or certificate of entities regulated or

licensed by it:

(a) If the applicant, licensee, registrant, or certificateholder, or, in the case of a corporation, partnership, or other business entity, if any officer, director, agent, or managing employee of that business entity or any affiliated person, partner, or shareholder having an ownership interest equal to 5 percent or greater in that business entity, has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless a repayment plan is approved by the agency; or

(b) For failure to comply with any repayment plan.

(2) In reviewing any application requesting a change of ownership or change of the licensee, registrant, or certificateholder, the transferor shall, prior to agency approval of the change, repay or make arrangements to repay any amounts owed to the agency. Should the transferor fail to repay or make arrangements to repay the amounts owed to the agency, the issuance of a license, registration, or certificate to the transferee shall be delayed until repayment or until arrangements for repayment are made.

(3) Entities subject to this section may exceed their licensed capacity to act as a receiving facility in accordance with an emergency operations plan for clients of evacuating providers from a geographic area where an evacuation order has been issued by a local authority having jurisdiction. While in an overcapacity status, each provider must furnish or arrange

for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity beyond 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending facility.

(4) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area where a state of emergency was declared by the Governor if the provider:

(a) Suffered damage to the provider's operation during that state of emergency.

(b) Is currently licensed.

(c) Does not have a provisional license.

(d) Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.

An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 6 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases

operations. The end of the inactive period shall become the licensee expiration date, and all licensure fees must be current, paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.

(5) ~~(3)~~ This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 381, 383, 390, 391, 393, 394, 395, 400, 408, 468, 483, and 641 or rules adopted pursuant to those chapters.

Section 14. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7203 CS PCB HCR 06-07 Obesity
SPONSOR(S): Health Care Regulation Committee
TIED BILLS: **IDEN./SIM. BILLS:** 1324

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care Regulation Committee	9 Y, 0 N	Bell	Mitchell
1) PreK-12 Committee	11 Y, 0 N, w/CS	Mizereck	Mizereck
2) Health Care Appropriations Committee		Money	Massengale
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 7203 CS addresses the issue of obesity in Florida. In 2000, more than six and a half million Florida adults were overweight or obese based on self-reported height and weight; and of those, approximately 2.5 million adults were obese. Its implications include serious health consequences such as diabetes, coronary heart disease, high blood pressure, high cholesterol, osteoarthritis, sleep disturbances and breathing problems, and certain cancers.

The bill requires the Department of Health (DOH or department), in addition to its current health promotion and prevention activities, to:

- Collaborate with other state agencies to develop policies and strategies for preventing obesity, which must be incorporated into programs administered by each agency and which must include promoting healthy lifestyles of employees of each agency.
- Advise Florida-licensed health care practitioners regarding the morbidity, mortality, and costs associated with the conditions of being overweight or obese, inform such practitioners of clinical best practices for preventing obesity, and encourage practitioners to counsel their patients regarding the adoption of healthy lifestyles.

According to the Department of Health, the changes made in the bill to s. 381.0054, F.S., will have an insignificant fiscal impact on state government.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote Limited Government—The bill directs the Department of Health to work with all the state agencies to offer wellness programming to employees and advise health care practitioners to provide healthy lifestyle recommendations to their patients.

Empower Families—Obesity is a serious risk factor for diabetes, heart disease, stroke, asthma, and many other chronic diseases. Early obesity interventions improve quality and quantity of life.

B. EFFECT OF PROPOSED CHANGES:

CURRENT SITUATION

The Prevalence of Obesity

The prevalence of obesity doubled in the past few decades. Today, approximately 129 million U.S. adults are considered obese. The number of overweight and obese persons in the country surpasses the number of people who smoke, live in poverty, or drink heavily. The U.S. Surgeon General recognized in 2001 that overweight and obesity have reached epidemic proportions in America.[1] An "epidemic" is defined as any disease occurring at a greater frequency than usually expected. Although historically the term "epidemic" referred to occurrences of infectious diseases, the definition has evolved to include chronic diseases and conditions such as obesity.

Defining & Measuring Overweight and Obesity

Overweight and obesity are both labels for ranges of weight that are greater than what is generally considered healthy for a given height. For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the "body mass index" (BMI). The BMI is calculated by dividing weight in pounds by height in inches squared, then multiplying the quotient by 703. An adult who has a BMI between 24 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. For children and teens, BMI ranges above a normal weight have different labels (at risk of overweight and overweight). Additionally, BMI ranges for children and teens are defined so that they take into account normal differences in body fat between boys and girls and differences in body fat at various ages.

Florida Statistics on Obesity and Overweight

In 2000, more than six and a half million Florida adults[2] were overweight or obese based on self-reported height and weight; and of those, approximately 2.5 million adults were obese. Since 1986, when height and weight were first monitored in Florida's adult population, overweight increased from 35.3 percent of the adult population in 1986 to 57.4 percent in 2002 to 60 percent in 2004.[3] The

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[1] U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001].

[2] Most of Florida data comes from the Behavioral Risk Factor Surveillance System (BRFSS). This is an on-going, state-based, random-digit dialed telephone survey of the general civilian population aged 18 and older. Youth Physical Activity and Nutrition Survey (YPANS) are used for data on physical activity, nutrition, and sedentary lifestyles among public middle school students, and the Florida Youth Behavior Survey (YRBS) is used to collect similar data among high school students.

[3] CDC BRFSS 2004 data. http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/florida.htm

prevalence of obesity has increased dramatically among both men and women between 1990 and 2002; for men the prevalence of obesity has increased 61 percent, and among women, the prevalence has increased 27 percent.

The BMI is also used to identify children who are overweight or who are at risk of becoming overweight.[4] In 2004, approximately 12.4 percent of Florida's high school students were considered overweight, with the rates for boys (16.5 percent) nearly doubling that of girls (8.1 percent). An additional 14 percent of Florida's high school students were considered at risk of overweight, with similar trends between boys (14.6 percent) and girls (13.4 percent). In 2002, nearly one-third of students in kindergarten, third, sixth, and ninth grades were significantly above their ideal weights.

Health Costs of Obesity & Overweight

Obesity is second only to tobacco use as a threat to public health. Its implications include serious health consequences such as diabetes, coronary heart disease, high blood pressure, high cholesterol, osteoarthritis, sleep disturbances and breathing problems, and certain cancers. Further studies conclude that obesity is linked to higher rates of chronic health conditions than smoking, drinking or poverty.[5] The U.S. Surgeon General reports that 300,000 deaths per year are attributed to obesity. The problem of obesity is especially dangerous for children. The adverse health conditions that typically occur in adults are becoming more prevalent in adolescents, and these conditions in childhood lead to chronic illness. One out of four children, who are overweight, show early signs of type 2 diabetes.[6] Overweight children are far more likely to become overweight adults than children who maintain normal weight through adolescence.[7]

Economic Cost of Obesity & Overweight

The U.S. Surgeon General announced that obesity and overweight cost U.S. taxpayers $117 billion per year in direct health care costs and indirect costs such as lost wages. Of this, the Centers for Disease Control (CDC) estimates that direct health care costs alone reached $75 billion in 2003. In Florida, obesity-related medical expenditures for adults total more than $3.9 billion in that year, with more than half of the costs financed by Medicare and Medicaid. Because of this, Florida's Agency for Health Care Administration (AHCA) reported that obesity and overweight have caused increased statewide healthcare expenditures for hospitalizations and treatments, including disability costs, related to chronic conditions.

Numerous studies have found a correlation between obesity and increased claims costs on insurance. A Kaiser-Oakland study found that individuals with a BMI of 30-30.49 had increased claims cost 25 percent; those with a BMI of more than 35 percent increased claims 44 percent. A Medstat Group study found that claims from individuals with a BMI of more than 27.5 percent cost 25 percent more than claims from those with an ideal body weight. Finally, a Bank One Study found that 24 percent of health care costs were because of overweight.

Causes of the Obesity Epidemic

In simple terms, obesity has reached epidemic proportions because our energy input through food exceeds our energy output through physical activity. Some contributors to this include larger meal portions, diets higher in fat, frequency of meals away from home, higher calorie and high fat drinks, and

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[4] These terms are defined based on a comparison of BMI to all other youth of the same age and sex. A child is considered at risk for overweight if his or her BMI is higher than the 85th percentile, and lower than the 95 percent percentile, of his or her peers. A child is considered overweight if his or her BMI is greater than or equal to the BMI of the 95th percentile of peers.

[5] RAND Corporation

[6] NEJM.

[7] National Library of Medicine

sedentary lifestyles. According to a recent study by the National Center for Health Statistics (NCHS), less than a third of U.S. adults engage in regular leisure-time physical activity. One study looked at adults who were trying to lose or not gain weight and found that less than 20 percent of them were following recommendations about increasing physical activity and reducing calories.[8] Another notable finding is that only 42.8 percent of obese people, who had routine checkups in past months, had been urged during those visits to lose weight.[9]

In 2002, only 25.7 percent of Floridian adults consumed five or more servings of fruit and vegetables a day. Also in this year, 26.4 percent of Floridian adults were physically inactive, with women and Hispanics the most likely to be sedentary. Even among those who reported being physically active, the level of intensity of physical activity has decreased since 1992.

Solutions for Handling the Obesity Epidemic

Changing people's habits related to physical activity is challenging. Individuals who want to be more active often find it difficult to do so because of daily demands and other constraints associated with work and family. The U.S. Surgeon General reported, in his 2001 "Call to Action to Prevent and Decrease Overweight and Obesity," that individual behavior can only change in a supportive environment, by giving people access to affordable and healthy food choices, and by giving people the opportunity for regular physical activity. A number of initiatives have been developed in both the private and public sectors to encourage individuals to adopt healthy nutrition and fitness behaviors.

Obesity Prevention in Florida

In October 2003, the Governor of Florida created a task force to address the rising rates of overweight and obesity among adults and youth in Florida, to evaluate data and testimony to determine the extent of the problem in Florida, and to make recommendations on how to address obesity in Florida.[10] The Governor's Task Force on the Obesity Epidemic issued a final report in February 2004, with 22 comprehensive recommendations.[11]

Section 381.0054, F.S., requires the Department of Health (DOH) to promote healthy lifestyles to reduce the prevalence of overweight and obesity in Florida by implementing appropriate physical activity and nutrition programs that target all Floridians. These activities include:

- Using all appropriate media to promote maximum public awareness of the latest research on healthy lifestyles and chronic diseases and disseminating relevant information through a statewide clearinghouse relating to wellness, physical activity, and nutrition and their impact on chronic diseases and disabling conditions.
- Providing technical assistance, training, and resources on healthy lifestyles and chronic diseases to the public, county health departments, health care providers, school districts, and other persons or entities, including faith-based organizations, that request such assistance to promote physical activity, nutrition, and healthy lifestyle programs.
- Developing, implementing, and using all available research methods to collect data, including, but not limited to, population-specific data, and track the incidence and effects of weight gain, obesity, and related chronic diseases. The department must include an evaluation and data collection component in all programs as appropriate.
- Partnering with the Department of Education, local communities, school districts, and other entities to encourage Florida schools to promote activities during and after school to help students meet a minimum goal of 60 minutes of activity per day.

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[8] Mokdad AH, Bowman, BA, Ford ES, Vinicor F, Marks JS, Koplan JP. The continuing epidemics of obesity and diabetes in the United States. *JAMA* 2001; 286(10): 1195-1200.
[9] Ibid.
[10] See Executive Order No. 2003-196.
[11] See http://www.doh.state.fl.us/Family/GTFOE/report.pdf (last visited on March 10, 2006).

- Partnering with the Department of Education, school districts, and the Florida Sports Foundation to develop a program that recognizes schools whose students demonstrate excellent physical fitness or fitness improvement.
- Maximizing all local, state, and federal funding sources, including grants, public-private partnerships, and other mechanisms, to strengthen the department's current physical activity and nutrition programs and to enhance similar county health department programs.

The department implements s. 381.0054, F.S., contingent on an appropriation in the General Appropriations Act. The department reports that the implementation of this section is not currently funded with an appropriation.

The Obesity Prevention Program within DOH is funded through a cooperative agreement with a planning grant of $450,000 from the United States Centers for Disease Control and Prevention (CDC). This funding must be used to develop infrastructure within the program in an effort to reduce the burden of obesity among adults and youth in Florida, develop partnerships to combat obesity, and develop a five-year work plan that focuses on increased physical activity, healthy nutrition, initiation and duration of breastfeeding, and decreased TV, video, or computer screen time.

During Fiscal Year 2004-05, DOH used media for public awareness through limited partner funds to conduct a direct-hit marketing campaign to affect physical activity in an identified five-county area, and a billboard campaign and bus placard campaign in Miami-Dade County to affect fruit and vegetable consumption. Because of the lack of funding, DOH has no plans for a public awareness media campaign for Fiscal Year 2005-06.

The department has launched an obesity prevention website that serves as a clearinghouse where limited resources can be downloaded and weblinks are available to other resources that may be purchased by the public. Limited resources are provided by DOH to county health departments, public or private agencies, schools, and community groups, as funding allows. Local media events are conducted by the Bureau of Chronic Disease Prevention and Health Promotion that cover all 67 Florida counties.

The Bureau of Chronic Disease Prevention and Health Promotion provides technical assistance to the public, county health departments, health care providers, school districts, and others who request assistance to promote physical activity, nutrition, and healthy lifestyle programs. The department uses the Behavior Risk Factor Surveillance System developed by CDC for state surveillance and data collection to assess overweight, obesity, physical activity levels, and fruit and vegetable consumption for adults. The department also surveys middle and high school students and conducts body-mass-index surveys on all full service school students enrolled in kindergarten, third, sixth, and ninth grades.

The department collaborates with the Department of Education through the school health program to promote the CDC School Health Index Assessment and conduct seven regional trainings for the school health advisory committee regarding the development of school wellness policies, which include increased opportunities for physical activity during and after school and the Step Up Florida physical activity campaign. On the local level, education coordinators for the Bureau of Chronic Disease Prevention and Health Promotion work with local schools to implement policy and environmental changes, as well as programs for during- and after-school physical activity. According to DOH staff, no state standards have been developed for measuring school physical fitness levels or methods to assess physical fitness or fitness improvement among students.

The department collaborates with several state agencies on specific projects and programs to address increasing physical activity and healthy nutrition, such as the school health program with the Department of Education and the safe ways to schools program with the Department of Transportation. The department maximizes local, state and federal funding to strengthen the Obesity Prevention

Program and other chronic disease prevention programs, through partnerships with state, local and federal organizations related to obesity prevention and related chronic diseases.

At the local level, the Bureau of Chronic Disease Prevention and Health Promotion emphasizes community-specific needs and planning, and establishes partnerships with local businesses, health care organizations, community organizations, schools, and faith-based organizations, requiring a 25 percent match in local resources, to address the leading preventable risk factors for all chronic diseases through community-based programs.

EFFECTS OF THE BILL

The bill amends s. 381.0054, F.S., requiring DOH, in addition to its current health promotion and prevention activities aimed at reducing the prevalence of excess weight gain and obesity, to:

- Collaborate with other state agencies to develop policies and strategies for preventing obesity, which must be incorporated into programs administered by each agency and which must include promoting healthy lifestyles of employees of each agency.
- Advise, in accordance with s. 456.081, F.S., Florida-licensed health care practitioners regarding the morbidity, mortality, and costs associated with the conditions of being overweight or obese, inform such practitioners of clinical best practices for preventing obesity, and encourage practitioners to counsel their patients regarding the adoption of healthy lifestyles.

The bill provides an appropriation of an unspecified amount from the General Revenue Fund to DOH to implement s. 381.0054, F.S.

The effective date of the bill is July 1, 2006.

BACKGROUND

Wellness Initiatives for State Employees

State governments have been increasingly active in encouraging healthy habits. A sample of programs is highlighted below.

Oklahoma: State employees are eligible to receive two wellness incentives in the OK Health Program. The first incentive offers employees an initial visit to a primary care physician along with lab work at no out-of-pocket cost. The second incentive is a discount at a participating fitness center. Agency directors are also given the authority to offer financial incentives to their employees who participate in the OK Health Program. The pay incentive program consist of three separate lump sum payable to an employee upon completion of specified steps and is available during the first year participation. The three levels of pay incentive are: $100 (Bronze), for enrolling in the program and completing the initial visit; $300 (Silver) for completing a twelve-week follow up visit; and $500 (Gold) for achieving goals at the twelve-month follow up.[12]

Arkansas: Offers nutrition counseling and smoking cessation aids, including the nicotine patch, to Medicaid recipients and state employees. Workers in the governor's office are offered "walking breaks" instead of smoking breaks.[13]

Wisconsin: The governor created, through an executive order, the Wisconsin Encourages Healthy Lifestyles (WEHL) initiative and council to promote healthy lifestyles for state employees. The WEHL

[12] Oklahoma's OK Health Program: http://www.ebc.state.ok.us/en/OkHealth/Finance_Incentives/FinancialIncentives.htm
[13] Kiely, Kathy. "Governor's healthy state." *USA Today.* July 7, 2004. http://www.usatoday.com/news/health/2004-07-11-arkansas-governor_x.htm

Council encourages each state agency to create its own council; designs a plan to promote the overall health and well-being of state employees; and is to identify incentives to promote participation by state employees in WEHL activities. The goals of WELH are to encourage physical activity for at least 30 minutes per day and to encourage healthy eating habits among state employees.[14]

Licensed Health Care Practitioners

Chapter 456, F.S., specifies the general provisions for licensed health care practitioners in DOH's Division of Medical Quality Assurance. In addition to chapter 456, F.S., each health care profession has its own practice act with specific regulatory provisions. Section 456.081, F.S., grants authority to DOH and the boards to advise licensees periodically, through the publication of a newsletter on the department's website, about information that the department or the board determines is of interest to the industry.

C. SECTION DIRECTORY:

Section 1. Amends s. 381.0054, F.S., directing the Department of Health to collaborate with other state agencies to develop workplace wellness programs and advise health care practitioners of the morbidity, mortality, and costs associated with obesity or overweight.

Section 2. Provides an unspecified appropriation.

Section 3. Provides the bill will take effect July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Department of Health Fiscal Impact

	1st Year	**2nd Year** (Annualized/Recurr.)
Estimated Expenditures		
Salaries and Fringe	**0**	**0**
Expense		
State Agency Obesity Prevention Workgroup	*$ 1,800*	*$ 800*
Funding for DCF, DOEA, ADP, AHCA, DJJ, DOA to Implement Obesity Prevention in current programs @ $5,000 each	*$ 30,000*	*$ 30,000*
Compliance with s.456.081 – Providing information to Healthcare Practitioners	*0*	*0*
Total:	**$31,800**	**$30,800**

[14] State of Wisconsin, Executive Order on WEHL Council. http://oci.wi.gov/special/wehlcoun.htm

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Section 381.0054, F.S., Healthy Lifestyle Promotion, is not currently funded. The Obesity Prevention program is funded by the Centers for Disease Control (CDC) and can only be used on CDC-approved projects. The appropriation section of the bill does not specify whether the funding only supports the changes made in the bill or the entire s. 381.0054, F.S.

Full implementation of s. 381.0054, F.S., is estimated by the Department of Health as $3,310,674 in year one and $2,341,319 in year two.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health has the necessary rulemaking authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 4, the PreK-12 Committee adopted two amendments to the bill. Amendment one removed the "Whereas" clauses. Amendment two removed the school district pilot program. This bill analysis is written to reflect the bill as amended.

CHAMBER ACTION

The PreK-12 Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the prevention of obesity; amending s. 381.0054, F.S.; requiring the Department of Health to collaborate with other state agencies in developing policies and strategies to prevent obesity which shall be incorporated into agency programs; requiring the department to advise health care practitioners regarding morbidity, mortality, and costs associated with the condition of being overweight or obese; requiring the department to inform health care practitioners about clinical best practices for obesity prevention and to encourage practitioners to counsel their patients regarding the adoption of healthy lifestyles; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (1) of section 381.0054, Florida Statutes, is amended to read:

381.0054 Healthy lifestyles promotion.--

(1) The Department of Health shall promote healthy lifestyles to reduce the prevalence of excess weight gain ~~overweight~~ and obesity in Florida by implementing appropriate physical activity and nutrition programs that are directed towards ~~target~~ all Floridians by:

(a) Using all appropriate media to promote maximum public awareness of the latest research on healthy lifestyles and chronic diseases and disseminating relevant information through a statewide clearinghouse relating to wellness, physical activity, and nutrition and their impact on chronic diseases and disabling conditions.

(b) Providing technical assistance, training, and resources on healthy lifestyles and chronic diseases to the public, county health departments, health care providers, school districts, and other persons or entities, including faith-based organizations, that request such assistance to promote physical activity, nutrition, and healthy lifestyle programs.

(c) Developing, implementing, and using all available research methods to collect data, including, but not limited to, population-specific data, and track the incidence and effects of weight gain, obesity, and related chronic diseases. The department shall include an evaluation and data collection component in all programs as appropriate.

(d) Partnering with the Department of Education, local communities, school districts, and other entities to encourage Florida schools to promote activities during and after school to

help students meet a minimum goal of 60 minutes of activity per day.

(e) Partnering with the Department of Education, school districts, and the Florida Sports Foundation to develop a program that recognizes schools whose students demonstrate excellent physical fitness or fitness improvement.

(f) Collaborating with other state agencies to develop policies and strategies for preventing obesity, which shall be incorporated into programs administered by each agency and shall include promoting healthy lifestyles of employees of each agency.

(g) Advising, in accordance with s. 456.081, health care practitioners licensed in this state regarding the morbidity, mortality, and costs associated with the condition of being overweight or obese, informing such practitioners of clinical best practices for preventing obesity, and encouraging practitioners to counsel their patients regarding the adoption of healthy lifestyles.

(h) ~~(f)~~ Maximizing all local, state, and federal funding sources, including grants, public-private partnerships, and other mechanisms, to strengthen the department's current physical activity and nutrition programs and to enhance similar county health department programs.

Section 2. The sum of $ is appropriated from the General Revenue Fund to the Department of Health for the 2006-2007 fiscal year to implement the provisions of s. 381.0054, Florida Statutes.

Section 3. This act shall take effect July 1, 2006.